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The Journal OF THE KENTUCKY STATE MEDICAL ASSOCIATION

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The JOURNAL of the

Kentucky State Medical Association

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Rehabilitation of the Patient With Hemiplegia

DONALD A. COVALT, M. D.

New York, N. Y.

The average length of life expectancy of a new-born child today is somewhere between sixty-eight and sixty-nine years as compared to the turn of the century when the average length of life expectancy was forty-seven years. As a people live longer, they naturally fall prey to chronic disease and the disabilities of old age. Patients with hemiplegia constitute one of the most frequent disabilities in this group, and it has been estimated that there are over one million patients with hemiplegia in the United States.

Causes of Hemiplegia

The causes of hemiplegia are apoplexy, trauma and congenital anomaly. Apoplexia may be caused by thrombosis, hemorrhage, embolism and cerebral vascular spasm. As every physician knows, it may not be possible to establish positively an accurate diagnosis as to the cause of a patient's apoplexia. However, when it is possible to determine that the hemiplegia has been caused by embolism or thrombosis, a rehabilitation program is started within forty-eight hours after the patient's cerebral accident. In the case of cerebral hemorrhage, a light exercise program is started within six to eight days. This is, of course, subject to clinical judgment of the physician as to the condition of the patient.

Tests of Prognostic Value

There are two simple tests which can be utilized by the physician to determine while the patient is still bedridden, whether or not he will eventually walk again. Firstly, if the patient is able to move the arm on the affected side, he will probably be able to learn to walk again since the arm is nearly always more severely affected than the leg; and, secondly, if the patient is able to raise the affected leg one inch off the sheet while lying in a supine position, there should be sufficient muscle power remaining to train the patient to walk again.

Read before the Annual Meeting of the Kentucky State Medical Association, September 22-24, 1953, Louisville.

Rehabilitation Procedures

Rehabilitation procedures should be started as early as possible for the patient with hemiplegia. There are certain simple procedures which can be of tremendous help in assisting the patient during the acute phase while he is still confined to bed. The earliest exercises must be light and include measures to prevent the deformities to which these patients are subjected. The regimen, in many instances, can be carried out in the home under the supervision of the physician by a physical therapist, a nurse, or even a member of the family.

1) A pillow should be kept in the axilla on the affected side at all times during the patient's stay in bed to prevent the adduction contracture of the arm to the side.

2) A foot board should be placed at the end of the bed or preferably a posterior leg splint should be applied to the paralyzed lower extremity to prevent foot drop on the affected side. The sheets should never be pulled tightly over the edge of the bed.

3) Sand bags should be placed laterally along the paralyzed leg to prevent outward rotation of the leg.

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4) The joints of both affected extremities should be carried through a complete range of motion passively twice a day, once in the morning and once in the afternoon. Particular attention should be given towards the shoulder joint since this quickly tends to become ankylosed and painful.

5) Quadriceps muscle setting should be carried out actively by the patient in order to maintain and increase the strength of this muscle group which will be needed for ambulation later. This should be done for fifteen minutes twice daily.

The patient should next be taught to sit up in bed. This activity may require assistance at first, but the patient will eventually be able to do this himself. A small rope is made from braided three inch bandage, tied to the end posts of the bed and brought up into a "U" pattern to two-thirds of the patient's length in bed in order that he may grasp it with his good hand. The patient is taught to place the affected hand on the rope with his good hand and to pull himself to an upright position using the affected arm as much as possible. It is important that the patient start sitting up in bed as soon as possible. He is taught to sit on the edge of the bed with his feet hanging over the edge of the bed. These patients lose their sense of balance very quickly if they are kept lying in bed for a short length of time.

Simple Mechanical Aids

After a short period of strengthening exercises in bed, the patient is ready to stand a few minutes by the side of the bed. By placing two ordinary kitchen chairs, one on either side of the patient, with the chair backs to the patient, the paralyzed hand may be bandaged to the top back rung of the chair and the patient is ready to practice standing balance. This should be done for five to ten minutes two or three times a day.

It is found that about fifty per cent of the hemiplegia cases require a foot brace to prevent inward rotation of the foot and to keep the toe from dragging. This should be made with a double bar with a cuff to the calf of the leg and with a ninety degree stop at the ankle. Stirrup braces with a joint should be provided at the same level as the ankle joint of the patient and should be removeable in order that the patient can change shoes as desired. If the patient does not have a serviceable quadriceps muscle and his knee buckles on walking, then a long leg brace will have to be made with a sliding lock at the knee joint. The lock should be placed on the inside in order that it can be locked and unlocked with the good hand.

When the patient has learned to stand between two chairs and his sense of balance has returned, it is time for him to start learning to walk again. The patient should be taught to walk with a reciprocal or crossed pattern. As the left hand pushes the left chair forward, the right foot is advanced. Correspondingly, as the right hand pushes the right chair forward, the left foot is advanced. The patient may require assistance at first with this activity, but he can be graduated quickly to a single cane held in the good hand and arm. The cane should be equipped with a suction cup rubber tip on the end.

Speech Therapy

If the patient is unable to talk, he should be seen by a speech therapist or pathologist. If possible, speech therapy should be instituted early in the course of the illness. It may be given by a speech therapist, speech pathologist, or, if such trained personnel is not available, by a speech teacher from a local high school or college.

The patient with hemiplegia usually has a very painful shoulder on the affected side with restriction of motion and should be taught how to do certain exercises for the upper extremity. A pulley can be arranged over the head of the bed to encourage movement of the arm on the affected side using the good arm and hand to extend the opposite arm. This exercise will help prevent the "frozen" and painful shoulder and should be done to the point of pain and repeated ten minutes twice daily. As the arm becomes more freely moveable, the pain becomes less and less and finally disappears. The family of a patient with a completely paralyzed upper extremity should be told that the prognosis for the return of function of the upper extremity must be very guarded.

Importance of Self Care

The patient with hemiplegia must be taught self-care activities such as how to tie his tie with one hand, how to feed himself, how to dress himself, etc. and the family must be instructed that it is not a kindness to do all of these activities for the patient, but rather they should assist in teaching the patient to do these things for himself.

Many patients with hemiplegia can be

taught to walk again and take care of their personal needs and even return to work again if the simple but effective exercises outlined above are utilized. The use of these exercises and procedures will prevent many of the deformities we see with these patients and will assist these patients to return to a useful life again.

Medical Responsibility in the Commitment of the Mentally Ill

FRANK M. GAINES, M. D.

Louisville

There are over 7000 patients now in Kentucky State mental hospitals. Last year 2300 patients were admitted to hospitals. Approximately two-thirds of these were admitted to State hospitals for the first time. Not only in Kentucky but in the United States at large, 95% of all mental hospital beds are in public hospitals. Therefore, the vast majority of Kentuckians who require mental hospital care enter hospitals which are supported by State funds and staffed by State employees. We are currently making every possible attempt, with the limited amount of money available, to make these hospitals the treatment hospitals which they should be. The problems in a large mental hospital are many and varied. One of the most pressing and one of the most difficult problems is to transform a hospital from a custodial institution to a hospital with progressive ideas and progressive methods of treatment. Modern psychiatry has made such progress in the last thirty years, even in poorly staffed and poorly supported public hospitals, as is shown by significant improvements in the recovery rate of mentally ill patients. The United States Public Health Service reports this year that in a sample of patients studied in 1914 and a similar group in 1948 the number of schizophrenics discharged in a year's time increased from 30% to more than 50% at the end of the first year of hospitalization. The rate of discharge of patients suffering from involutional psychosis increased from 35% to 70% in this same period. Thirty years ago many involutional patients died during the course of their hospitalization, through suicide or concurrent debilitating illness. The Public Health study shows a decrease in the death rate from 22% in 1914 to an average of 4% in 1948. A similar decrease in death rate can be demonstrated for syphilis of the nervous system as well.

Read before the Annual Meeting of the Kentucky State Medical Association, September 22-24, 1953, Louisville.

The Lack of Public Understanding

These statistics show graphically the trend in the medical treatment of the mentally ill in public hospitals in the United States, and they serve to emphasize the vast gap between our medical knowledge and public understanding of treatment of the mentally ill. A large number of misconceptions exist among laymen concerning mental health. A national survey of these misconceptions presented the following conclusions:

1. The popular stereotype of the mentally ill is that of violently "insane." It is commonly believed that patients with mental disorders must be separated from society because they are dangerous, don't know what they are doing, and are not responsible for their actions. In general, little distinction is made between psychosis, neurosis, and other forms of disturbance.

2. Many forms of mental disorder which are actually quite severe but do not manifest bizarre or violent behavior are not recognized as serious. Rather, they are attributed to "quirks of character," or "just human nature."

3. When people are urged to express their views, two concepts of the cause of mental disorder frequently emerge. The first one of these is that all "insanity" is produced by such physical factors as heredity, disease of the brain, menopause, aging, or "weakness of the nerves." The second attributes mental disorder to some sort of individual weakness of character, lack of self-control, self-indulgence or other moral lack. Many intelligent laymen persist in the misconception that the "mental" and "physical" components of the human being are somehow two independent entities seated respectively in the "mind" and the "body."

4. The possibility of cure for "insanity" is generally, but incorrectly, assumed to be quite low. A somewhat more hopeful

view is held for mental disorders of less severity, but this is largely because persons with these milder afflictions are "not really insane."

5. The functions of the psychiatrist, with whom the ordinary layman has had little or no contact, are poorly understood. He is commonly conceived of as a doctor whose therapeutic function is "to tell people what is the matter with them." Treatment consists of imparting this knowledge and "talking to them."

6. Since society must "protect itself from the insane" by sending them to mental institutions, the mental hospital to many people symbolizes a place of sheer custody.

7. Many believe that numbers of patients are "railroaded to asylums" unjustly and without cause.

These ideas people generally have about mental illness are reflected in our laws governing the State care of the mentally ill.

Development of Legislation

In colonial times there were no laws concerning the commitment of the mentally ill. Commitment could be effected with the greatest of ease and there was no specific legislation to safeguard the personal liberty of the supposedly mentally ill person. In 1845, in the Supreme Court of Massachusetts an important ruling was handed down by the court confirming the right of the government to restrain a mentally ill person not only by regard for personal and public safety but also by considerations of remedial treatment. A second important lawsuit occurred in 1849, in which a former patient of a mental hospital brought suit against a number of persons who had been associated in placing him in the hospital and had succeeded in obtaining heavy damages. During the 1860's two other events of a different character exerted considerable influence on subsequent legislation in the United States. One was the appearance of a "best seller" novel which was built around the illegal commitment of a sane young hero to a private asylum through the influence of business associates seeking to separate him from his modest fortune. The second event was the case of Mrs. E. P. W. Packard who was committed to an Illinois hospital by her husband, and who, after she was discharged from the hospital, sponsored legislation in Illinois and other states to protect the personal rights of persons who were said to be mentally ill. As a result of these and other factors, most states adopted formal legislation outlining the methods by which a person could be sent to a mental hospital involuntarily. However, some of these laws were so bent on protecting the person's liberty and rights they lost sight of the basic fact that the law primarily dealt with a sick person who needed to be placed in a hospital for treatment. Consequently, heavy reliance was placed in many states upon a trial before judge and jury in which the patient was treated more like a criminal than a sick person. Our own State has a law providing jury trial, which in more recent years has been somewhat tempered by other simpler methods of admission to State hospitals.

Defects of Present Laws

The worst features of contemporary commitment laws are as follows (not all of these are true of the present Kentucky law however):

1. Legal service and notice to the patient of his impending trial.

2. Insistence of personal appearance in court of the patient.

3. Exposure of the patient as a public spectacle and a public record of such.

4. Emphasis of lay judgment as in trial by jury. Identification of mental illness and criminality by similarity of procedure.

5. Common acceptance of certification of mental illness as tantamount to legal incompetence, rather than a clear separation of these as different issues affecting the rights of persons.

6. Use of out-moded terminology.

7. Inquiry into the patient's financial status at the time of commitment.

Recommended Reforms

General recommendations towards the reform in commitment law lie in the following general direction:

1. The revision of admission and release procedures which retain the pattern of criminal procedures.

2. Increased reliance on medical examination and certification of mental illness with a proviso that there be adequate protection for the patient's rights, and also protection of the physician's role as an examiner. This would primarily mean the deemphasis of trial by jury and the emphasis of voluntary admission and a simplified method of involuntary admission to

a hospital. The practice of serving notice on a patient personally of a judicial hearing should be discontinued, as should also the requirement that the patient appear in open court. However, legal notice must be given to kin and the patient must be represented by proxy in court.

3. The temporary commitment should be used as an emergency measure in order that patients may be sent directly to a hospital rather than to jail.

4. Out-moded terminology should be remedied and such words as "commitment" should be replaced by the term "certification;" "insanity" and "lunacy" should be replaced by the term "mental illness," and the terms "feeble-minded" and " weak-minded" should be abandoned.

5. The obligation of the patient or his family to pay for the patient's maintenance in a hospital is recognized, but inquiry into his financial status should not serve as a bar to his admission when early admission and early treatment are so essential.

6. Admission procedures to a mental hospital should be completely divorced from incompetency procedures.

Some of these recommendations are already present in our current Kentucky laws and some are followed as accepted informal practices in our courts, so that the sting of the formal law is somewhat tempered in its application. However, there are a number of serious discrepancies still apparent, and these center primarily around modernizing the language of the law, minimizing the judicial machinery and simplifying admission on medical grounds. It is extremely important that every doctor in Kentucky recognize these problems and the proposed changes. In every community the family physician is not infrequently called in consultation to arrange for the admission of a patient to a State hospital, and, if our recommendations are adopted, his role as the examiner of the mentally ill patient will become more important.

Summary

In summary, we wish to propose legislation which will preserve patients' rights and personal liberties, but which will also provide for humane treatment based on the most modern methods of medical treatment.

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Athletic Injuries

O. B. MURPHY, M. D.

Lexington

This subject will be discussed in a general way in the hope of stimulating thoughts towards the diagnosis, as well as the prevention and management of athletic injuries and disabilities.

Since the appearance in 1940 of progress reports on the isolated topic of athletic trauma, many publications have appeared concerning lesions and injuries of similiar types, but not necessarily incident to athletics. Advances have been made in the treatment of trauma, whether due to physical agents of industrial occupational hazards, or to war. Much of the same pathology exists as a result of athletic trauma.

Basketball, a very tiring sport, has risen to the higher brackets of professional and scholastic interest, as well as income, but in the grade and high schools the duration of playing time is reduced, and the rest periods increased because of the physical demands made on young players. Our high schools and equivalent preparatory institutions are the reservoirs of athletes. In this period the player faces danger, with youth competing against youth, but unless the school physician is especially trained in the management and prevention of disabilities, vital physiological and emotional defects are overlooked in the would-be athlete which could result in injury. Yet, we provide no effective means for the sound physical evaluation of athletes with a view of preventing disabilities, or to uncovering any hidden physical defects that may terminate their competitive activities. We cannot successfully combat the

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dangers of body contact unless we carefully scrutinize the physiological mechanism of the contestant. Athletic equipment, we admit, has made competition safer, but there is a definite lack of medical participation in the field of disability prevention.

The adolescent years are fruitful, yet dangerous for the athlete. The structure of his body is developing, but has not yet reached physical maturity. For example, long bones are more susceptible to fractures, epiphyseal separations and dislocations, etc. Frequently, young tissues, while fresh, virile and flexible, have neither matured nor been trained sufficiently to develop the tensile strength so necessary for the stresses they must withstand. The coach, or manager, particularly in high schools, frequently overlooks what might be temperament, lack of courage or competitive spirit. The knowledge of past performance, work habits and emotional stability might have produced a stellar performer instead of a washed-out, would-be athlete.

Developments in the last decade have produced a greater comprehension of the pathology of injury resulting from the trauma of physical agents, such as fire. The human organism and its reaction to the effects of burns is better understood than before. Similarly, with the development of the sulphonomides and anti-biotics, the control of bacterial infection incident to the complications of trauma have reduced potential dangers and death. However, death from athletic trauma still does occur. Of course, one might say that deaths still occur in appalling numbers as a result of highway accidents, or even of accidents in the home. The surgeon responsible for the medical supervision of organized athletics remains interested not only in reducing the incidence of serious injury, but in reducing the morbidity, and particularly time lost caused by injury in an all too short sport season.

Incidence of Athletic Injuries

The incidence of trauma among our male college population has been computed as representing 20% of all the diagnoses made in representative student health departments. It seems appropriate, therefore, to review the literature that has appeared in reference to the diagnosis and treatment of various types of injuries incident to organized athletics. Unfortunately, trauma from athletics will always be present, both in professional and amateur sports. This discussion will be limited to those regions of the body most frequently injured in those sports with the greatest number of participants in order to cover the common morbidity of injuries sustained in competitive athletics, particularly those sports concerned with body contact.

McPhee, reporting the situation in football at Princeton, analyzed the injuries sustained by 524 players during a period of 10 years. This, and other reports, have indicated that sprains, strains and contusions represent a large proportion—approximately 80% of the injuries sustained; fractures and dislocations represent 10%; and internal injuries, mostly cerebral concussions, represent between 4% and 7%.

It is regrettable that more analyses from the athletic and health departments in our large universities are not available. Hibert analyzed for the school year 1948 and 1949 the athletic injuries sustained by over 46,000 athletes in 4 states of the Rocky Mountain, Pacific-Northwest, and Southwest regions. He found that 86.3% were due to football; that 1 out of 5 participants sustained injuries; that 68% of football injuries occurred in players 16 and 17 years of age; and that 70% occurred in players with less than 2 years experience.

This paper will emphasize the three major body regions most commonly injured in competitive sports, notably the *shoulder*, the *knee*, and the *ankle*.

Shoulder Girdle Injuries

Injuries to the shoulder girdle are common, and consist of fractures of the various bones making up this region, dislocations, sprains of certain ligaments, and contusions. To present better the diagnosis of specific shoulder injuries, it is of tremendous advantage to the examiner to have some definite method of examination. The purpose of immediate examination is to rule out the probability of any of the more serious types of injury, namely fracture and dislocation. By observation little can be discovered directly through apparatus and uniforms worn today. Indirectly, however, shoulder injuries can be spotted by observing the way a player carries or uses an injured shoulder, or how he protects it. The favoring of an arm and the inability to use it freely are signs observable from the sidelines. By palpation, the surgeon should first look for a deformity, tenderness and abnormal mobility along the bony prominences of the clavicle. This

will rule out the three common injuries to this region, dislocation of the sterno-clavicular joint, dislocation of the acromioclavicular joint, and fracture of the clavicle. Furthermore, by palpation, deformity of a dislocation of the shoulder is readily ascertained. The more serious types of injury must be either diagnosed or ruled out before the surgeon tests for the less serious sprains and contusions. To localize the latter he resorts to muscle and joint function tests. These tests are carried out first passively by the surgeon, and then actively by the player against slight resistance. For the shoulder region they consist of flexion-extension, abduction-adduction, external and internal rotation. Such tests against moderate resistance aid greatly in localizing shoulder injury.

Acromio-clavicular and sterno-clavicular sprains in the ligaments holding the inner or outer end of the clavicle are common. They are produced either by a direct blow on the shoulder lateral to the acromium process, by falling with considerable force on the elbow, or by a sudden backward wrench of the shoulder. The latter, produced mainly in wrestling, loosens and partially tears and dislocates the sterno-clavicular joint. The former type of fall produces the acromioclavicular sprain or separation. Swelling and localized tenderness over these joints, with marked loss of power of the arm on active, functional tests, make the diagnosis obvious. This injury to the acromio-clavicular joint is sometimes complicated by a fracture of the acromium process which is proved by roentgen ray only. The immediate treatment is that of strapping over a soft cotton wadding or sponge rubber pad for 48 hours followed by daily diathermy and local massage. There are all degrees of tearing of these ligaments and the period of convalescence varies from 4 to 12 days, averaging about 9 days. I have not encountered a single case in this age group that could be recommended for surgical repair.

The most common severe injury to the shoulder is that of dislocation of the head of the humerus. The diagnosis of this injury is obvious, both by observation and palpation. The treatment, of course, is immediate reduction, preferably on the field, and the best method which I have employed has been the method described by Hippocrates with the foot in the axilla and traction made upon the extended arm with the player lying in the supine position on the ground. As traction is applied, slight adduction of the arm is performed, and also slight external rotation, and most usually, prior to the onset of muscle spasm about the shoulder joint, the reduction may be rapidly carried out. If, after the first attempt, reduction is not successful, then of course the player should be taken to the nearest facility where either a brachial block or general anesthetic can be administered and reduction then carried out. Following reduction the arm is bound to the side by a compression spica bandage about the shoulder, and the forearm maintained in a sling. This bandage remains in place for a period of approximately 3 weeks after which time passive and active motions of the elbow and shoulder are carried out with caution and restriction to the motions of external rotation and abduction. Following this the player is permitted to return to practice, but usually with a restrictive harness which prevents over-extension, abduction or external rotation of that extremity. If the player sustains a recurrent dislocation following his first dislocation, then it is usually recommended that some of the more formidable surgical procedures of repair, such as Bankhardt's or Magnussen's be carried out. The Bankhardt operation, of course, consists of repair of the defect in the anterior capsule in the glenoid rim, whereas the Magnussen consists of transfer of the subscapularis outwardly on the head of the humerus, which in itself serves as a check ligament for external rotation and abduction.

In those instances in which surgical intervention is necessary, the question always arises as to whether these players should be permitted to participate in further football activities. I believe that if the repair is adequate and the surgeon performing the repair is satisfied that firm fixation of the structures involved has been carried out, that these players could satisfactorily return to participation in competitive athletics.

Injuries of the Knee

Since the knee is the region of the body most frequently injured in competitive sports, one looks forward to the day when protective equipment, adhesive strapping or bracing, may solve the problem of reducing the incidence of this particular trauma. However, it is the most exposed and mechanically weakest of the major joints. Superficial contusion, muscle contusion and joint sprain are easily sustain-

ed, particularly in body contact force. Sprains of the collateral and cruciate ligaments are relatively easily produced in view of the long lever arms of the femur and tibia. However, no less important is the stress and strain of rotation of the femur on the tibia that is produced by pivoting, a common maneuver in many of our contact sports.

In the examination of a knee the most important item to consider is the manner of the occurrence of injury. Was it a twist or strain, or was it a straight contusion? The next item is to ascertain the point or points of tenderness to palpation, first palpating along the joint capsule anteriorly, then the vastus medialis and lateralis for presence of muscle contusion, and the medial and lateral ligaments, and finally the joint margins of the tibia in the region of the meniscus attachments. These points must be palpated to elicit tenderness, and remember . . . . there will be no swelling to guide the examiner if he makes his examination in the first minute or two of injury. If the knee is locked in flexion, the diagnosis is probably a meniscus displacement or other internal derangements.

After the examination by palpation, tests are made for abnormal joint mobility, both in the lateral and in the anterior-posterior planes. It is simple to detect abnormal motion when one has a normal leg to compare with it. It is impossible, however, to detect this unless the player completely relaxes the muscles of his thigh. Tenderness over an externally palpable ligament, together with increased lateral mobility and pain in that ligament when it is put on a stretch, localizes the injury there.

After the diagnosis and localization of the point of injury in a knee, the next step is the determination of the extent of injury. I have found that the examination of an athlete following an acute knee injury is quite difficult because of the intense pain incident to that injury. For this reason, if severe injury of the knee joint is suspected, it is recommended that prior to positive evaluation, some form of anesthesia be administered. It has been our practice to instill local anesthesia into the points of most severe pain and tenderness to remove the inhibiting effects of pain and assure thorough evaluation of the injury. Under anesthesia abduction-adduction instability can readily be determined, and if necessary, X-rays in forced abduction or adduction at the knee will readily demonstrate abnormal mobility resulting from tears of the medial or lateral collateral ligaments. In conjunction with this examination, abnormal mobility in the anterior-posterior plane, indicating injury to the cruciate ligament, can also be demonstrated.

Treatment of Knee Injuries

The treatment of injuries about the knee joint, of course, is directly determined by the extent of damage. In mild sprains of the knee joint the usual method of treatment of joint sprains is carried out. The player is removed from play and placed on non-weight bearing for a period of approximately 48 hours. The joint is immediately treated with a firm, compression bandage over sponge rubber and sheet wadding, and the joint is kept immersed in ice-cold water for a period of approximately one-half hour to discourage hematoma formation. In addition to this immediate treatment, we have found that the instillation of pontocaine anesthesia with the addition of 1,000 TR units of hyaluronidase injected into the points of maximum tenderness insures more rapid rehabilitation of mild sprains of the collateral ligaments of the knee. The purpose of the instillation of the local anesthesia with hyaluronidase in conjunction with compression dressings is that it seems to insure more rapid absorption of the hematoma and metabolites incident to the ligament strain, and therefore decreases the severity of pain. With the decrease or absence of pain in mild sprains of the knee joint ligaments, the athlete may more easily carry out rehabilitation resistant quadriceps exercises which will insure his more rapid return to competitive sports.

If the radiological examination of the knee joint under anesthesia reveals a complete tear of the medial or lateral ligaments, then obviously, the stability of the knee joint can only be restored by the operative repair of ligamentous tears, and I strongly advocate that severe tears of the medial or lateral-collateral ligaments of the joint be repaired by surgical means. The question as to whether an athlete who has incurred mild or severe injuries to the knee joint may return to activity in competitive sports, naturally must be answered by the team physician. The index that I use as to whether an individual following a knee injury, regardless of severity, is to return to competitive athletics, depends primarily upon the stability of the

knee and the strength of his quadriceps mechanism, which is regarded as the primary stabilizer of the knee joint. For this reason I demand that any player having incurred sprain of any degree of severity employ active non-weight bearing resistant exercises of his quadriceps muscle prior to returning to competitive activity.

Meniscus Tears

The next most common injury of the knee sustained by athletes is that of meniscus tear, either the medial or lateral meniscus being torn, the medial of course, being most common. The mechanism of production of meniscus injuries is an exaggerated form of the manner in which collateral ligament sprains and tears of the knee joint occur in contact sports. In football the tibia is usually fixed to the ground by the cleats of the football shoes and is thus unable to follow violent rotation of the femur. Extreme internal rotation of the femur on the tibia in flexion causes the medial meniscus to be forced toward the posterior compartment of the joint, first by reason of the attachments of the medial-collateral ligament, which exerts traction in a posterior direction, and second, by the rotary force of the medial femoral condyle which forces it into a posterior central plane. When the joint is suddenly extended the meniscus is caught in this abnormal position and trapped against the head of the tibia, resulting in a posterior longitudinal tear. If the longitudinal tear involves the posterior third only, the entire meniscus will eventually spring back into a normal position and the joint does not lock. If, however, the tear extends forward beyond the plane of the ligament, the condyle traps the meniscus against the tibia at the extreme anterior limit of the tear, and cannot regain its normal position and the joint locks. This injury in football is usually incurred when the player is in a semi-crouched position with the quadriceps muscle relaxed and is blocked by the opposing player from the side, forcing the femur into internal rotation, the knee into abduction, and thereby trapping the medial meniscus.

External rotation of the femur in flexion and adduction are responsible for tears of the lateral meniscus. These tears are less common in football because the player is less seldom caught or trapped in this position.

The treatment of meniscus tears, after they are positively diagnosed, should consist of the application of a compression bandage, with or without aspiration, depending upon the volume of effusion; rest in bed, or ambulation on crutches; the immediate institution of quadriceps drill; the removal of the compression bandage several times daily for knee flexion exercises; and operation in one to three weeks depending on the incidental damage to the joint and the progress of preoperative treatment.

Before closing the discussion on injuries to the knee joint, I should like to re-emphasize the importance of the quadriceps muscle. This muscle has been identified by many as the key to the knee. Development or re-development of the quadriceps muscle should be the by-word of every training room. Manipulations and operations may be performed and the joint may be immobilized, but no matter what other treatment is necessary, active non-weight bearing exercise must be practiced. Simple strains, traumatic synovitis, rupture of ligaments, tearing of semi-lunar cartilages, and fractures into the joint—almost every injury of the knee—must be treated by regular quadriceps drill.

Ankle Joint Injuries

Injuries to the ligamentous tissue of the ankle in athletes are common, and seriously disabling lesions that require longer periods of convalescence than any team coach would like to permit. It is, nevertheless, possible to return such patients to play within 7 to 10 days, depending upon the severity of the lesion. To shorten the period of recovery is the aim of all surgeons.

Three degrees of injury to the ligaments of the ankle joint must be recognized.

1. Sprain due to stretching or tearing of fibers of the external ligament; the stability of the joint being normal.
2. Dislocation due to complete avulsion of the anterior middle bands of the external ligament from the malleolus, with undue mobility of the talus which is displaced out of the tibiofibular mortis whenever the foot is inverted. Momentary dislocation of the joint, and its recurrence with every inversion movement is recognized only by special clinical and radiographic tests.
3. Varying degrees of tear of the anterior tibio-fibular ligaments with the production of a tibio-fibular diastasis.

As in the knee, degrees of disability in injuries about the ankle joint are directly proportional to the severity of ligamentous damage. A recently injured ankle joint is exquisitely tender and painful, and complete examination and evaluation are markedly interfered with by pain. Therefore we advocate, as in the knee, injections with local anesthesia at the points of tenderness about the ankle joint and X-rays in forced inversion, to determine the stability of the talus within the ankle mortis, and forced eversion, to determine the stability of the mortis, to prove or disprove severe injury to the lateral-collateral or anterior tibio-fibular ligament.

Treatment of Ankle Injuries

If the ankle joint is determined to be stable following these tests, then the routine treatment of compression dressing and application of cold compresses, with later whirlpool and massage and protective ankle strapping, is carried out. If the sprain is determined to be relatively minor and no instability of the ankle joint exists, then the treatment should be directed toward the prevention of swelling or the subsidence of edema and swelling if such has already occurred. I am convinced that the delay in recovery of a relatively minor ankle sprain is due to the adhesions secondary to the swelling and edema resulting from the ligament injury. Pain, when persistently present, acts to discourage mobility and encourage edema. For this reason I advocate the use of pontocaine and 1,000 TR units of hyaluronidase injected into the points of pain. Following this injection the patient is not permitted to return to full weight bearing activities, but is placed on a rigorous program of non-weight bearing table exercises consisting of active inversion-eversion, plantar and dorsi-flexion exercises of the foot and ankle. The ankle is strapped during all weight bearing activities and the player is not permitted to return to competitive sports until the ankle is asymptomatic.

The treatment of the more severe forms of ligamentous tears determined by X-ray examination, are those of a surgical nature. Complete tears of the lateral-collateral ligament are repaired after the method of Watson-Jones by using the peroneus brevis muscle tendon threaded through the lateral malleolus and the neck of the astragulus, to follow the normal path of the collateral ligament prior to its being torn. Complete tears of the anterior tibio-fibular ligament producing a tibio-fibular diastasis are repaired surgically by transfixing the fibula to the tibia with a short lag screw. Before the screw is cinched tight, the foot should be held in right angle dorsi-flexion. If the screw were tightened while the foot were in equinus and the narrow posterior part of the talus were engaged in the ankle mortis, it would be difficult later on to engage the wider anterior part of the talus and fully dorsi-flex the ankle joint.

In preparing this paper I have purposely left out the more severe disabilities such as fractures of long bones, etc., because in the usual competitive sports, these severe injuries are relatively rare.

Recent Trends in the Diagnosis and Management of Patients With An Abnormal Tendency to Bleed

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The purpose of this paper is to review some of the practical applications which have arisen from recent research on the physiology of blood coagulation. It is at present impossible for anyone but the researcher in coagulation problems to keep up with the recent literature in this field. Biggs and Macfarlane[1] estimate that in the year 1949-50, there were no less than 400 papers published dealing with the clotting of blood and the tempo certainly has not lessened since then. Since these were produced in several countries, and also because various schools of coagulation research use different names to describe the same blood clotting factor, the literature abounds with such confused terminology as to make the whole subject incomprehensible except to those with special interest in these problems. However, much of a practical nature has arisen from this research. The discovery of vitamin K and

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its application to surgery in the jaundiced patient, and the prevention of hemorrhagic disease of the new-born was a great advance in knowledge. The introduction of the coumarin group of drugs made possible the present widespread use of anticoagulant therapy in the treatment of thromboses. In addition, more exact laboratory tests have made more precise diagnosis possible in sufferers from bleeding disorders. An extra burden has been placed on the hospital pathologist who is now called upon routinely to perform and understand tests which would have been considered erudite by research workers in the coagulation field ten years ago. In this paper therefore, will be discussed the principles underlying some of these newer tests and the information they can give concerning better understanding of the nature of the hemorrhagic tendency, and its more intelligent management.

The Modern Theory of Blood Coagulation

Most of the techniques currently employed in studying blood clotting abnormalities depend in principle upon assumptions derived from the theory of the reactions which occur when blood is withdrawn from a vein and allowed to clot in a tube. These reactions are unduly complex, and by no means perfectly understood. There are practical disadvantages in basing a test upon a theory as yet unproven. An example is provided by the controversy which has existed for years over the suitability of the Quick[2] method for estimating prothrombin in plasma. When this test was introduced, it was a theoretically sound method for the estimation of prothrombin in the light of what was then known concerning blood coagulation. The discrepancies later found by workers using this test were due to the fact that the underlying reactions are more complicated than was at that time thought. The test is still very useful, but it is now known that factors besides the prothrombin content of the plasma influence the result.

Much of the basic work on the theory of blood coagulation has employed the method of isolating the various plasma components of the clotting mechanism in as near pure form as possible, and then observing what happens when these components are allowed to interact in a test tube in various combinations under various conditions. However, these factors are so similar in many of their physico-chemical properties that it is almost an impossibility to prepare them in a pure state. They may also be altered in the many manipulations of plasma required for their isolation, and may not represent the substances as they naturally occur in the blood. In spite of these objections, this line of research has been very fruitful. By these methods it has been shown that prothrombin is quantitatively converted to thrombin during coagulation[3], and that the time of clotting of fibrinogen by thrombin is inversely proportional to the concentration of thrombin present.

Nature from time to time presents us with an ideal opportunity to study the importance and mode of action of a particular clotting factor. Although it is almost impossible to prepare in the laboratory a plasma deficient in only one factor, rare cases of naturally occurring specific deficiencies of the various factors are encountered. Much has been learned from a detailed study of such plasmas, so that considerable knowledge of normal coagulation has been directly derived from the study of the abnormal[1].

The theory of blood coagulation proposed by Morawitz[4], in 1905 is still held to be fundamentally correct. Thrombin is believed to be formed in clotting blood, which acts enzymatically on the fibrinogen of the plasma to convert it into fibrin. Fibrin is laid down in strands which enmesh the blood cells, and the blood is then said to have clotted. This change from fibrinogen to fibrin is the only phase of the coagulation mechanism we can observe, and then only from the viewpoint of speed. Morawitz postulated that thrombin could not exist preformed in the blood (or else it would convert the plasma fibrinogen intravascularly), but must develop from an inactive precursor, prothrombin, during the process of coagulation. Two factors, ionized calcium and thromboplastin liberated from damaged tissues were necessary for this conversion, it being known that tissue extracts would accelerate clotting. The scheme may be written thus:

Thromboplastin + calcium + prothrombin forms thrombin.
Thrombin + fibrinogen forms fibrin.

It is now known that thromboplastin is formed in the blood itself during clotting, and blood does not require tissue contamination to clot. This plasma thromboplastin can be formed in the test tube under experimental conditions,[5,6] and the factors

necessary for its formation studied. When blood is freshly drawn from a vein without contamination with tissue juice, and placed to clot in a glass tube, plasma thromboplastin does not appear until just before the clot appears. When it does develop, it is extremely powerful, being able to clot plasma in some instances in eight seconds, which is faster than the best brain thromboplastins available. It now seems that at least five factors are necessary, in the presence of a foreign surface, for plasma thromboplastin to be formed. One of these is derived from the blood platelets. The other four are all plasma constituents. They are anti-hemophilic globulin, Christmas Factor, Factor V and Factor VII. Anti-hemophilic globulin is the name given to a plasma constituent which is normally present, and which when deficient, gives rise to the clinical condition of hemophilia. Christmas Factor[7] is the latest of the coagulation factors to be recognized. In its absence, a hemorrhagic disease is produced which has been tentatively called Christmas Disease after the name of the first patient studied in detail. Factor V[3] has been given various names by different workers: accelerator globulin[8], prothrombin accelerator[9], and the labile factor[10]. In its absence, a severe hemorrhagic disorder may result. Factor VII[11] is probably identical with prothrombin conversion factor[12], serum prothrombin conversion accelerator[13], proconvertin and convertin[14]. The thromboplastin generation test[6] has shown that anti-hemophilic globulin, platelets, Christmas Factor and Factor VII must all be present for plasma thromboplastin to be formed. Further work with this test[15] has indicated that Factor V is probably also concerned with the thromboplastin mechanism. Plasma thromboplastin in the presence of calcium is able to convert prothrombin to thrombin. Figure I is an attempt to represent schematically the reactions which occur in clotting blood.

Factor V and Factor VII were formerly thought to be accelerators of prothrombin conversion i.e. to act in conjunction with preformed thromboplastin in the conversion of prothrombin to thrombin, and not to be necessary for the formation of thromboplastin. This was because in plasmas deficient in either Factor V or Factor VII, prothrombin conversion is delayed in the presence of excess calcium and brain thromboplastin. Brain thromboplastin however, is not a complete thromboplastin. It can probably be considered to be a prothromboplastin[1] and must react with both Factor V and Factor VII before a complete thromboplastin, comparable with what occurs in plasma is formed.

Blood coagulation is an auto catalytic phenomenon, thrombin being able to accelerate its own formation. Once thrombin has begun to appear, the reaction rapidly completes itself. This accounts for the sudden appearance of clot in blood after quite a considerable latent period during which no obvious reactions are occurring.

The Prothrombin Consumption Test

When normal blood is allowed to clot in a tube at 37° C., the prothrombin present is mostly converted to thrombin shortly after the blood clots. This thrombin is then either adsorbed onto the fibrin meshwork of the clot or neutralized by plasma anti-thrombin. If the serum from such a blood is analyzed an hour after clotting has taken place, usually very little prothrombin will be demonstrated. The ratio of plasma prothrombin time to serum prothrombin time is termed the prothrombin consumption index. Normally this is less than 40%. If there has been inadequate conversion of prothrombin to thrombin during the process of clotting, a high residual serum prothrombin activity will be found. This is indicative of defective manufacture of plasma thromboplastin, and usually

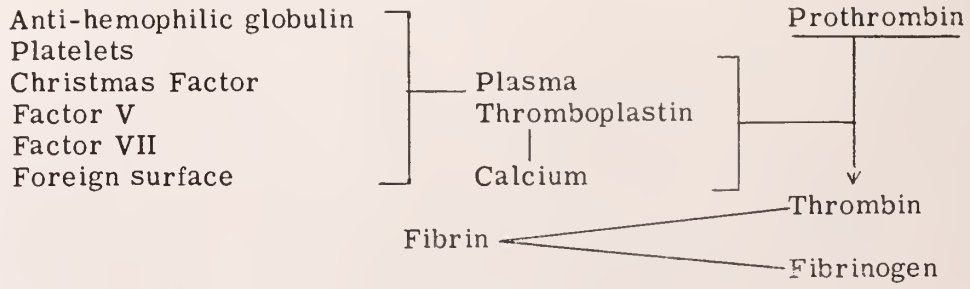


Figure I: A Simplified Theory of Blood Coagulation

means a deficiency of either anti-hemophilic globulin or platelets. This is the basis of the prothrombin consumption test[16-18]. The test would be expected to be abnormal in hemophilia, thrombocytopenia from any cause provided the platelets are sufficiently reduced, and in Christmas Disease. Deficiency of either Factor V or Factor VII will also reveal abnormal prothrombin consumption, but because brain thromboplastin is used in estimating the prothrombin times, modifications in the technique are necessary when dealing with deficiencies of these substances.

In Figure II are shown the results obtained with this test, using the method of Merskey[16], in six cases of hemophilia, six cases of thrombocytopenia and six normal individuals. The thrombocytopenia in three cases was thought to be idiopathic, in two cases it was the result of aplastic anemia, and in one case acute leukemia. In general, the degree of abnormality of this test in thrombocytopenia bears some correlation to the platelet count.

The main importance of the prothrombin consumption test lies in its ability to distinguish the mild case of hemophilia. In classical hemophilia, where there is a family history of bleeding tendency, a case history of excessive bleeding from childhood, and a prolonged whole blood coagulation time, the diagnosis is not in doubt, and it is seldom necessary to resort to other laboratory tests. However, cases of hemophilia with a normal coagulation time are by no means uncommon. In Merskey's[19] series of 51 cases of hemophilia, 17 showed a clotting time of less than 12 minutes. When it is considered that in 28 out of 72 patients (39%) studied by him there was no family history of bleeding, it can be readily seen that in many cases additional laboratory confirmation of hemophilia is required. In only three instances in his series was the prothrombin consumption index in the normal range (i.e.40%). In 12 cases of hemophilia studied by the author the prothrombin consumption index has ranged from 55 to 200%. Most of these cases have been investigated on several occasions. In no instance has a normal prothrombin consumption test been obtained.

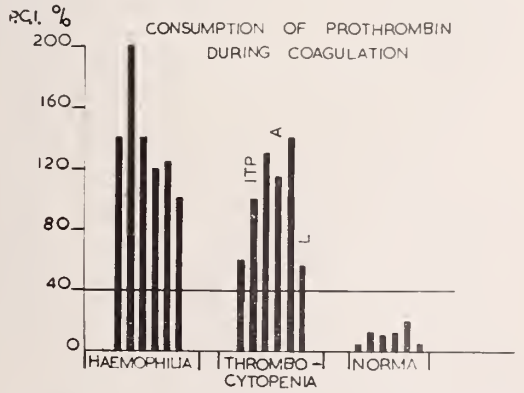


Figure II: Results with the Prothrombin Consumption Test in Hemophilia and Thrombocytopenia as compared to normal subjects.

The prothrombin consumption test has also proved of value in controlling therapy in hemophilia. If a hemophiliac is given a blood or plasma transfusion because of hemorrhage, it is common knowledge that the coagulation time may be reduced to normal and yet the patient continue to bleed. If hemorrhage still persists, the defect in the hemostatic mechanism must still be present, in spite of a normal coagulation time. In these cases, the prothrombin consumption test will still give an abnormal result. Estimation of the coagulation time alone is a crude method of judging improvement of the clotting defect in hemophilia. Certainly in the very rare occasion upon which it is imperative to operate upon a case of hemophilia in an endeavor to save life, every effort should be made to restore the prothombin consumption index to normal by plasma or blood transfusion, and keep it within the normal range until the danger of post operative hemorrhage has ceased to exist. This is the minimum of laboratory control necessary, and surgery should not be attempted in its absence.

The abnormal prothrombin consumption test in thrombocytopenia is of great interest theoretically, but of little practical importance, as the diagnosis will be manifest by the platelet count. In the rare condition of thrombosthenia[20-22], a hemorrhagic disorder in which the platelet count is normal, but the platelets are morphologically and functionally altered, the prothrombin consumption test is reported to be abnormal.

Thrombin Generation Test

Macfarlane and Biggs[23] studied the generation of thrombin in freshly drawn whole blood by subsampling from the clotting sample at frequent intervals into tubes containing fibrinogen. The time of clotting of the fibrinogen tubes is depend-

ent upon the concentration of thrombin in the subsample of whole blood carried over. By reference to a calibration graph prepared by adding known concentrations of thrombin to fibrinogen, the amount of thrombin present at successive intervals in the blood sample can be deduced. After a latent period of some minutes, there is a sudden generation of thrombin in native whole blood allowed to clot in a tube. The thrombin evolved rapidly reaches a maximum concentration, and thereafter declines as the thrombin is neutralized by plasma anti-thrombin. The peak of thrombin production does not take place until after clotting has occurred.

Pitney and Dacie[24] modified this test to employ citrated plasma, and used it to investigate the coagulation defect in their cases of hemophilia. In Figure III are shown the thrombin generation curves obtained when the plasmas in eight cases of hemophilia were recalcified, compared to the normal range. In hemophilia there is a considerable lag phase before thrombin can be shown to have been generated in the recalcified plasma. The concentration of thrombin then slowly increases and in many cases is only reaching its maximum level at the conclusion of the experiment. This gradual evolution is in striking contrast to the rapid increase in thrombin concentration observed in normal plasma. In general, the more severe the grade of hemophilia as judged by other laboratory criteria, the more abnormal is the pattern of the thrombin generation curve. The upper four curves in the figure were from patients with coagulation times of 20 minutes or less. The lowest two curves were from patients with the longest coagulation times in this series. This test, by allowing a dynamic visualization of plasma clotting, gives information which neither the coagulation time nor the prothrombin consumption test can provide.

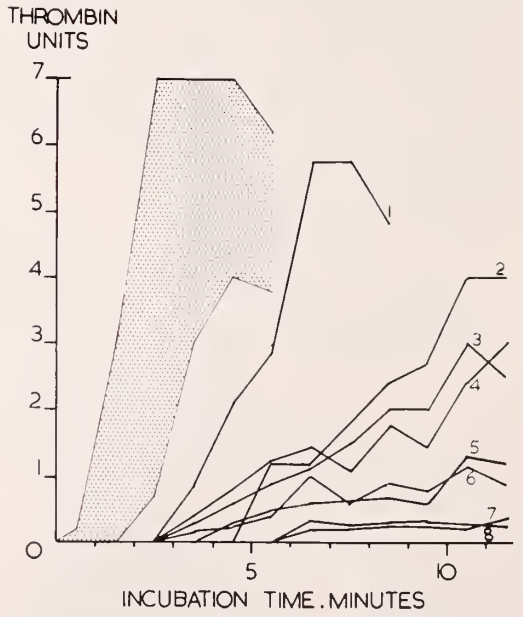


Figure III: Thrombin generation in eight hemophilic plasmas. The normal range is illustrated for comparison. (from: J. Clin. Path., 6,9, 1953)

By the use of the thrombin generation test, it is possible to show that it is necessary to transfuse large volumes of fresh plasma to cases of hemophilia to achieve a notable correction of the coagulation abnormality. Much smaller quantities are required to bring the coagulation time back to the normal range[25]. In Figure IV are shown the thrombin generation curves obtained from a hemophilic boy, aged 14 years, before and immediately after the intravenous infusion of 380 ml. of fresh (4 hour) plasma. The post infusion curve although improved, was still abnormal. The coagulation time however, was reduced from 45 minutes to 8 minutes, which is well within the normal range. This type of experiment again shows that information obtained by following the coagulation time alone in hemophilia can be misleading.

The thrombin generation test has also been used to evaluate the anti-hemophilic potency of fibrinogen fractions of plasma which, freeze dried, are sometimes used in the treatment of hemophilia (Cohn's Fraction 1). Here again, much larger amounts than are currently employed should probably be used if any worthwhile correction of the clotting defect is to be expected.

The Thromboplastin Generation Test

If normal plasma is adsorbed by aluminum hydroxide gel, prothrombin, Factor VII and Christmas Factor are almost completely removed. The resulting alumina plasma retains however, anti-hemophilic globulin and Factor V. If to this plasma is then added normal serum (containing Factor VII and Christmas Factor), a saline suspension of washed normal platelets and calcium chloride, all the components are present for the manufacture of plasma thromboplastin. The mixture will not clot because there is no prothrombin

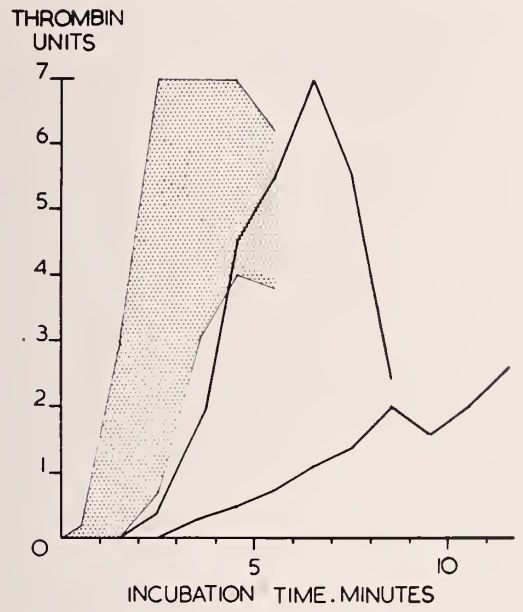


Figure IV: Thrombin generation in a hemophilic plasma before and after the administration of 380 ml. fresh plasma to the patient. (from J. Clin. Path., 6, 9, 1953)

present. However, the generation of thromboplastin can be followed by subsampling from the mixture into normal plasma in the presence of calcium, and observing the speed with which the normal plasma clots. Biggs and Douglas[6] have described a thromboplastin generation test using this principle. Using normal alumina plasma, normal serum, and normal platelets, a very potent plasma thromboplastin is formed which is capable of clotting plasma in eight seconds in some instances. When alumina plasma from a case of hemophilia is used as a source of anti-hemophilic globulin in this test, thromboplastin formation is much reduced. The test has been used to assay the anti-hemophilic globulin concentration of plasma in cases of hemophilia. By this test the efficiency of treatment in hemophilia can also be judged. Biggs and Douglas describe a case in which a hemophilic child, aged six and one half, was given one pint of fresh plasma and 2/3 pint of fresh whole blood before tooth extraction. The whole blood coagulation time and the prothrombin consumption test were reverted to normal, but the thromboplastin generation test remained abnormal. The child bled more than a normal person following the extractions.

The thromboplastin generation test may also be used to show deficiencies of serum factors (Christmas Factor and Factor VII). In such cases, the test serum is incubated with normal alumina plasma and normal platelets and the thromboplastin which is generated assayed. A case of thrombosthenia has been studied with the thromboplastin generation test. Normal alumina plasma, normal serum and the patient's platelets generated very little thromboplastin. When normal platelets were substituted, there was the normal amount of plasma thromboplastin generated. This test promises to be very useful in the study of obscure clotting defects.

The Laboratory Distinction Between Hemophilia and Christmas Disease

By definition, hemophilia is a disorder brought about by congenital deficiency of a plasma coagulation factor, anti-hemophilic globulin. A small amount of normal plasma when added to hemophilic plasma in the test tube is able to supply enough anti-hemophilic globulin to materially shorten the time the plasma takes to clot when recalcified. Dilutions of known hemophilic plasma when added to the test plasma however, will be ineffective. This is the basis of a sensitive test for hemophilia, the use of which has allowed the recognition of a hemorrhagic disorder caused by deficiency of a previously unrecognized coagulation factor, the Christmas Factor[7]. The disease presents all the usual laboratory findings of hemophilia. However, when plasma from a case of Christmas Disease is mixed with true hemophilic plasma the clotting time of the mixed plasmas is much less than either alone; in fact, the mixture clots normally. This phenomenon of apparently classical hemophilic bloods mutually correcting each other has been also recorded by Aggeler, et al.[26]. These workers also realized they were dealing with a deficiency of a previously unrecognized blood coagulation factor, which they called Plasma Thromboplastin Component (PTC). The new factor is best obtained from serum and the thromboplastin generation test reveals that its presence is necessary for the manufacture of normal plasma thromboplastin.

In Christmas Disease, anti-hemophilic globulin is present in the blood in normal amounts. Likewise cases of hemophilia show a normal component of the Christmas Factor. Like classical hemophilia, cases of Christmas Disease show a normal skin-prick bleeding time, a normal pro-

thrombin time, prolonged coagulation time and abnormal prothrombin consumption test. Like hemophilia also, the defect can be corrected by the addition of normal plasma to the test plasma in vitro. However, hemophilic plasma is as effective as normal plasma, and the addition of the fibrinogen fraction of plasma, while effective in hemophilia, will not shorten the clotting time of plasma in Christmas Disease. This has practical significance because cases of Christmas Disease should be treated by the infusion of whole blood or plasma, and not by the dried fibrinogen fractions. In Table I, the properties of Christmas Factor and anti-hemophilic globulin are compared.

The Laboratory Control of Anticoagulant Therapy

The Quick[2] one stage prothrombin test is used extensively for the control of therapy in patients being treated with either dicoumarol or tromexan because of thrombosis. There has in the past been much discussion concerning what this test does measure in plasma. Some workers have felt that the more refined tests for prothrombin, such as described by Owren[27] and Owren and Aas[28] are superior for the routine control of these patients. Certainly the Quick test cannot be relied upon to measure prothrombin. The test is influenced by the Factor V and Factor VII content of the plasma, by the concentration of fibrinogen, and by the presence of inhibitors such as heparin in the blood. The test is apparently more sensitive to deficiencies of Factor V and Factor VII than it is to prothrombin. Biggs and Douglas[29] describe a case of hypoprothrombinemia occurring as a single entity. In this patient, the Factor V and Factor VII content of the plasma were normal. The prothrombin concentration however, was estimated by a special technique to be reduced to 10% of normal, yet the Quick prothrombin time was little altered. In dicoumarol plasma, reduction in Factor VII content is probably more important than reduction in prothrombin from the viewpoint of altering the hemostatic mechanism. In tromexan plasma, Factor VII deficiency is the main abnormality. Methods for prothrombin estimation in plasma which add an excess of Factor V and Factor VII should not be used to control anticoagulant therapy. While they may give a more accurate indication of the true prothrombin content of the plasma than is possible with the Quick test, yet they do not measure the overall coagulation defect, which clinically determines the liability of such patients to bleed. The Quick test measures a combined deficiency of clotting factors. It has now been standardized through prolonged usage so that

Table I: Properties of Christmas Factor and Antihemophilic Globulin (from: Brit. Med. J., II, 1378, 1952)

Method of Differentiation	Christmas Factor	Antihemophilic Globulin
Ammonium sulphate fractionation	Precipitated from normal plasma by 33-50% saturation	Precipitated from normal plasma by 25% saturation
Ether fractionation	Precipitated from normal plasma in crude alpha and beta globulin fraction	Precipitated from normal plasma in fibrinogen fraction
Test for presence in normal serum	Present in large amounts	Almost absent
Test for presence in hemophilic serum	Present in large amounts	Absent
Stability to heat	Destroyed by heating to 56°C. for 10 minutes	When isolated from plasma resists heating to 56°C. for 10 minutes
Stability on storage	Stable	Often unstable
Effect of Seitz filtration	Adheres to filter	Is unaffected
Effect of adsorption with $Al(OH)_3$	Very readily adsorbed	Not adsorbed

the therapeutic and dangerous ranges are known, and has the added merit of being simple to perform, thus making it very suitable as a routine laboratory test.

Summary

In this paper are described several laboratory tests which have been found useful in investigating the clotting mechanism. Of these, the Prothrombin Consumption Test is the simplest to perform, and often gives valuable information particularly in the mild case of hemophilia. This test is better than the whole blood clotting time for the control of therapy in a hemophiliac receiving blood or plasma transfusions.

Tests to distinguish hemophilia from Christmas Disease are described. The Quick one stage Prothrombin Time is the recommended technique for the control of dicoumarol therapy.

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The Lewis Rogers Memorial Meeting of the Kentucky State Medical Association

Columbia Auditorium, Louisville, Kentucky, September 21, 23, 1953

Digest of Proceedings of the Regular Sessions of the

HOUSE OF DELEGATES

Hugh L. Houston, M.D., Murray, Speaker of the House, presiding

First Session

The first session of the House of Delegates of the Kentucky State Medical Association was called to order by the Speaker, Hugh L. Houston, M.D., at 7:10 P.M. The meeting took place at the Columbia Auditorium. D. G. Miller, Jr., M.D., Chairman of the Reference Committee on Credentials, reported that a quorum was present.

A motion was made and seconded that the meeting be held in executive session. Motion carried. A motion was made that the reading of the minutes of the 1952 meeting be dispensed with, as they are published in the Journal. Motion was seconded and carried.

At this time Doctor Underwood read the names of all physicians who had died since the 1952 meeting.

Following are the names of the physicians:

Backsman, Elmore B., (Member) Cold Springs, Nov. 29, 1952

Barr, R. Haynes, (Member) Owensboro, May 5, 1953

Beckman, Richard P., (colored) Louisville, March 1, 1953

Berresheim, Frieda K., Louisville, March 22, 1953

Boone, Benjamin E., (Member) Elkton, April 9, 1953

Brown, William M., (Member) Lexington, February 23, 1953

Buckner, W. T., Shelbyville, February 2, 1953

Bullock, W. O., (Member) Lexington, January 23, 1953

Connelly, Walter C., Salyersville, December 18, 1952

Corum, George T., (Member) Corbin, April 25, 1953

Cowan, J. Rice, (Member) Danville, August 17, 1953

DeWitt, Charles C., (Member) Louisville, April 19, 1953

Dotson, Donald C., (Member) Owingsville, July 16, 1953

Duncan, John T., (colored) Louisville, June 22, 1953

Estill, R. Julian, (Member) Versailles, October 10, 1952

Evans, J. T., Middlesboro, October 2, 1952

Ferguson, Omer Earl, (Member) Owensboro, April 26, 1953

Forwood, W. S., Henderson, December 5, 1952

Franklin, A. L., Providence, May 30, 1953

Fulton, Gavin, (Member) Louisville, September 9, 1953

Galloway, C. A., Corydon, March 25, 1953

Gholston, S. R., (colored) Richmond, June 3, 1953

Henderson, Elmer L., (Member) Louisville, July 30, 1953

Herndon, Robert H., Ft. Mitchell, October 4, 1952

Ison, G. D., Blackey, April 5, 1953

Jackson, Arley M., Frankfort, October 3, 1952

Johnson, A. L., Richmond, June 4, 1953

Keffer, Smithfield, Grayson, October 24, 1952

Lowry, Thomas M., Lexington, December 12, 1952

McDevitt, Coleman J., (Member) Murray, February 5, 1953

McKenna, Paul K., (Member) Mt. Sterling, February 20, 1953

McMahan, E. R., Bloomfield, July 6, 1953

McNeely, Mont, (Member) Wingo, October 5, 1952

McReynolds, S. S., Russellville, March 25, 1953

Martin, Pierce, Fourmile, March 19, 1953

Moore, John Walker, (Member) Louisville, November 10, 1952

Morton, Charles R., (Member) Madisonville, March 22, 1953

Murphy, Charles E., Finley, April 12, 1953

Mullikin, Josiah W., Ewing, January 23, 1953

Neel, W. Hal, Bowling Green, July 28, 1953

Nash, William H., (Member) Shelbyville, September 14, 1953

Neff, Charles O., (Member) Louisville, July 20, 1953

Newsom, Goebel W., (Member) Praise, May 15, 1953

Putnam, John L., Lebanon, July 7, 1953

Ransdell, Marvin S., (Member) Prestonsburg, May 25, 1953

Reesor, O. R., (Member) Louisville, January 21, 1953

Rose, Edward A., Louisville, December 29, 1952

Rutledge, Harold H., (Member) Richmond, February 11, 1953

Scott, J. Murray, (colored) Hopkinsville, March 6, 1953

Smith, Earle E., (Member) Bardwell, May 13, 1953
Snyder, S. B., (Member) Hazard, May 1, 1953
Spitzelberger, Lawrence M., Dayton, April 9, 1953
Stull, Samuel L., Flaherty, May 3, 1953
Sumner, Roy S., (Member) Owensboro, February 3, 1953
Teater, Rice M., Nicholasville, October 21, 1952
Toll, James L., Lawrenceburg, October 9, 1952
Wedekind, Robert, (Member) Louisville, March 10, 1953
Westerfield, A. A., Utica, December 10, 1952
Wilder, Don E., (Member) Booneville, April 5, 1953
Williams, S. H., Crofton, August, 1953
Willis, Palestine, (Member) Beaver Dam, April 9, 1953

A minute of silent prayer was observed in their honor.

Clyde C. Sparks, M.D., Chairman of the Council, informed the House that the Council had received only one nomination each for the General Practitioner Award and the Distinguished Service Award. Since the Council is supposed to present three nominations from the names received for each Award, the Council had voted to recommend to the House that nominations be made from the floor. A motion was made and seconded that the House be allowed to nominate from the floor candidates for the two Awards. Motion carried. A motion was made and seconded that the name of R. Haynes Barr, M.D., be placed in nomination for the Distinguished Service Award as a posthumous honor for his work in public relations and his outstanding leadership in the Association. A motion was made that nominations cease. Seconded and carried. Doctor Barr was unanimously awarded the Distinguished Service Medal.

A motion was made and seconded that the name of C. T. Coleman, M.D., of Frankfort, be placed in nomination for the Outstanding General Practitioner Award. Motion carried. A motion was made and seconded that the name of J. I. Greenwell, M.D., of New Haven, also be placed in nomination for the Outstanding General Practitioner Award. Motion carried. After a brief explanation of the nominees' qualifications, it was put to vote and Doctor Greenwell was awarded the General Practitioner Award. Doctor Sparks pointed out that the names the Council had received had been included in the nominations from the floor.

At this time the following reports were presented and referred by the Speaker to the indicated reference committee.

Report of the President—Reference Committee No. 1

Report of the President-Elect—Reference Committee No. 1

Report of the Speaker—Reference Committee No. 1

(Dr. Houston read the list of his appointments for the reference committees and the alternate appointments. Motion was made and seconded the personnel of the reference committees be approved. Motion carried.)

Reference Committee Appointments are as follows:

Reference Committee No. 1—Reports of Officers and Councilors

E. M. Howard, M.D., Harlan, Chairman
Lawrence T. Minish, Jr., M.D., Louisville, Vice-Chairman
C. F. Long, M.D., Elizabethtown
Wendell V. Lyon, M.D., Ashland.
William R. McCormack, M.D., Bowling Green

Reference Committee No. 2—Reports on Medical Care, Medical Education, Hospitals and related subjects

W. Vinson Pierce, M.D., Covington, Chairman
Richard G. Elliott, M.D., Lexington, Vice-Chairman
Garnett J. Sweeney, M.D., Liberty
Ward Bushart, M.D., Fulton
Chris Jackson, M.D., Danville

Reference Committee No. 3—Reports on Legislation and Public Relations

Richard J. Rust, M.D., Newport, Chairman
Gradie R. Rowntree, M.D., Louisville, Vice-Chairman
Carl Fortune, M.D., Lexington
B. Ralph Wilson, M.D., Sharpsburg
Ralph D. Lynn, M.D., Elkton

Reference Committee No. 4—Reports on Miscellaneous Business

T. O. Meredith, M.D., Harrodsburg, Chairman
Wyatt Norvell, M.D., New Castle, Vice-Chairman
Karl D. Winter, M.D., Louisville
Frank T. Linton, M.D., Princeton
W. B. Atkinson, M.D., Campbellsville

Reference Committee No. 5—Reports on Miscellaneous Business

Charles B. Stacy, M.D., Pineville, Chairman
John C. Quertermous, M.D., Murray
Carl Pigman, M.D., Whitesburg
John W. Scott, M.D., Lexington

Credentials Committee No. 6

D. G. Miller, Jr., M.D., Morgantown, Chairman
Glenn W. Bryant, M.D., Louisville, Vice-Chairman
H. C. Denham, M.D., Maysville

Alternate Committee Members

H. G. Wells, M.D., Georgetown
J. D. Handley, M.D., Hodgenville
George F. Archer, M.D., Louisville
Donald L. Graves, M.D., Frenchburg
Everett H. Baker, M.D., Louisville

Reports of the Officers, Council and Committees were received at this time and assigned to Reference Committees as follows:

Report and Recommendations of the Council—Reference Committee No. 1
Report of the Secretary and General Manager—Reference Committee No. 1
Report of the Editor—Reference Committee No. 1
Report of the Treasurer—Reference Committee No. 1
Report of A.M.A. Delegate—Denver Session—Reference Committee No. 1
Report of A.M.A. Delegate—Washington Session—Reference Committee No. 1
Report of A.M.A. Delegate—New York Session—Reference Committee No. 1
Committee on Arrangements—Reference Committee No. 5
Committee on Scientific Assembly—Reference Committee No. 2
Public Relations Committee—Reference Committee No. 3
Committee on Medical Service—Reference Committee No. 2
Committee to Study the Constitution and By-Laws—Reference Committee No. 3
Medico-Legal Committee—Reference Committee No. 3
Kentucky Committee for Contributions to American Medical Education Foundation—Reference Committee No. 2
Committee on Corporate Practice of Medicine—Reference Committee No. 2
Committee to Rearrange Councilor Terms—Reference Committee No. 4
Diabetes Committee—Reference Committee No. 2
Advisory Committee to the Editor—Reference Committee No. 2
Education Campaign Committee—Reference Committee No. 3
Committee on Emergency Medical Service—Reference Committee No. 5
Committee on Hospitals—Reference Committee No. 2
Insurance Committee—Reference Committee No. 2
Kentucky State Advisory Committee to Selective Service—Reference Committee No. 4
K.S.M.A. Dental Committee—Reference Committee No. 2
K.S.M.A. Pharmacy Committee—Reference Committee No. 2
K.S.M.A. Physicians Placement Committee—Reference Committee No. 4
Legislative Committee—Reference Committee No. 3
Board of Directors of McDowell Memorial Foundation—Reference Committee No. 4
Committee on Medical Education—Reference Committee No. 2
Committee for Special Article on Medical Education—Reference Committee No. 2
Committee to Study Medical Examiner System—Reference Committee No. 3
Medical School Advisory Committee—Reference Committee No. 2
Supplemental Report of Medical School Advisory Committee—Reference Committee No. 2
Committee on Nurse Training—Reference Committee No. 2
Committee on School Health—Reference Committee No. 5
Professional Relations Committee—Reference Committee No. 3
Committee on Rural Health—Reference Committee No. 5
World Medical Association Committee—Reference Committee No. 5
Committee on Veterans Affairs—Reference Committee No. 4
Advisory Committee on Blood Banks—Reference Committee No. 2
Advisory Committee on Cancer—Reference Committee No. 2
Advisory Committee on Crippled Children—Reference Committee No. 2
Advisory Committee on General Practice—Reference Committee No. 2
Advisory Committee on Industrial Medicine and Surgery—Reference Committee No. 2
Advisory Committee on Mental Hygiene and Mental Institutions—Reference Committee No. 2
Advisory Committee on Obstetrics—Reference Committee No. 2
Advisory Committee on Pediatrics—Reference Committee No. 2
Advisory Committee on Physical Therapy—Reference Committee No. 2
Advisory Committee on Public Health—Reference Committee No. 2
Advisory Committee on Tuberculosis—Reference Committee No. 2
Advisory Committee on Blue Cross—Reference Committee No. 4
Advisory Committee to the State American Legion—Reference Committee No. 5
Advisory Committee on United Mine Workers Health and Welfare Fund—Reference Committee No. 3
Advisory Committee to Woman's Auxiliary—Reference Committee No. 5
Committee on Scientific Exhibits—Reference Committee No. 2
Committee on Technical Exhibits—Reference Committee No. 2
Report of Woman's Auxiliary—Reference Committee No. 5
Report of the Board of Directors of Kentucky Physicians Mutual, Inc.—Reference Committee No. 4
Supplemental Report of the Board of Directors of Kentucky Physicians Mutual, Inc.—Reference Committee No. 4
Report on Rural Kentucky Medical Scholarship Fund—Reference Committee No. 3
Report on Medical Research Commission—Reference Committee No. 2
Conference of Presidents and Other Officers of State Medical Associations—Reference Committee No. 3
Report of the Member of the Advisory Council to University of Louisville Medical School, Student A.M.A. Chapter—Reference Committee No. 2

The following new business was presented and referred by the Speaker to the indicated reference committee.

Resolution on McDowell Memorial Foundation —Reference Committee No. 4

Resolution of Taylor County Medical Society concerning Telephone Seminars—Reference Committee No. 2

Resolution of Taylor County Medical Society concerning the Veterans Administration program—Reference Committee No. 4

There being no further new business, a motion was made and seconded that the meeting adjourn at 10:05 P.M. Motion carried.

Second Session

The second session of the House of Delegates of the Kentucky State Medical Association was called to order by the Speaker, Hugh L. Houston, M.D., at 7:15 P.M. The meeting took place at the Columbia Auditorium. D. G. Miller, Jr., M.D., chairman of the Reference Committee on Credentials, reported that a quorum was present.

Clyde C. Sparks, M.D., chairman of the Council, introduced the following resolution from the Council to the House of Delegates:

"WHEREAS, the 1953 Annual Meeting has been a substantial success, and

WHEREAS, many individuals, organizations, and agencies including technical exhibitors, newspapers, radio and television stations, state and national scientific essayists, hotels and the Columbia Auditorium,

NOW THEREFORE, be it resolved that the House of Delegates go on record as expressing its deep appreciation to all who have had a part in its development and implementation."

A motion was made and seconded that the resolution be approved. Motion carried.

At this time the reports of the reference committees were presented.

Reference Committee No. 1
E. M. Howard, M.D., Chairman
(Reports of Officers and Councilors)
Report of the President

After paying tribute to the late Robert Haynes Barr, M.D., the president recommended that the House revise the system of electing vice-presidents and making them working instead of honorary officers. He proposed that the vice-president from the district from which the president was serving automatically succeed the president and that he be invited to attend meetings of the Council and be given assignments that would fit him to take over in case the office was vacated.

Attention was directed to the need for increasing the Association's income, but it was suggested that the Association's program should be reviewed from time to time with the view of eliminating unnecessary activity. The need for the medical profession in Kentucky to present a unified front and the need for enlistment of the largest possible number of physicians as members was emphasized. The membership was called on to assume its responsibility in all matters pertaining to the field of health and medicine.

The report was concluded with an expression of appreciation to the Council and officers of the Association for the splendid cooperation the president had received.

Reference Committee No. 1 has considered the Report of the President which was discussed in some detail. It is recommended that special thought be given to the election of an active and interested vice president from the same section of the state as the president in order that he may successfully carry on the duties of the office in the event of death or disability of the president. It is further recommended that all the vice presidents be considered as actual assistants to the president, and therefore be actively indoctrinated in the work of the Association in order to help when possible in assisting the president in carrying his ever-increasing administrative load.

It is further recommended that Dr. Graves be commended for his thoughtful report.

The Committee recommends adoption of this section of its report.

Motion was made, seconded and carried that the report of the president be adopted.

Report of the President-Elect

The president-elect commented on the tremendous volume of work being done by the officers and Council and told of meetings he had attended. He said there is still a good deal of public relations work to be done to present the profession in the proper way to both the public and the press.

The Committee next considered the Report of the president-elect and recommends the adoption of this section of the report.

Motion was made, seconded and carried that the Report of the President-Elect be adopted.

Report of the Speaker

Highlights of the speaker's report included encouraging county societies to elect delegates early and to take an active part in planning the meeting and in the Association's affairs, appointment of a Nominating Committee, Reference Committees and Committee on Rearrangement of Councilor Terms. He thanked the members for the privilege of serving them.

The Committee next considered the Report of the Speaker of the House of Delegates. It wishes to thank the speaker for his three years of arduous service. It recommends that this section of the report be adopted.

Motion was made, seconded and carried that the report of the Speaker be adopted.

Report of the Council

The report of the Council was presented by Clyde C. Sparks, M.D., chairman. Dr. Sparks read the 19-page report, which was a digest of the proceedings of the five meetings the Council had held prior to the Annual Meeting. The positive actions of the meetings of the Executive Committee of the Council were also listed.

The first meeting was held October 9, 1952, which was the reorganization session. Following the election of officers and the election of Council committees, the Council authorized the Committee on Medical Service to proceed with the indigent medical care survey and voted to send an invitation to the Southern Medical Association to meet in Louisville in 1954.

The second meeting was held December 18. Nominees for the vacancy for the State Board of Health were made and it was decided that all meetings of the House of Delegates in the future be held as executive sessions. Formation of district advisory committees to the United Mine Workers of America Welfare and Retirement Fund was authorized and the K.S.M.A. Legion Committee was asked to study the veterans home-town medical care contract. Abandonment of the procedure of carrying verbatim stenotyped reports of the House of Delegates was voted when it was pointed out that the procedure cost approximately $600 for the 1952 meeting.

At the third meeting, April 23, the budget for the 1953-54 year, as drawn by the Budget Committee and approved by the Executive Committee, was presented with a $2500 item added by the Executive Committee to cover the traveling expenses of the president and president-elect. With this addition, the budgeted deficit on the basis of income from sources then available showed $13,000, and the Council voted to recommend to the House of Delegates that the annual dues be increased as of January 1, 1954, from $25 to $35. The proposal that the verbatim reports of the House of Delegates be deleted from the December issue of the Journal on the ground that printing them was a very expensive procedure, increasing the cost of that issue some $800, was approved.

The request for Council endorsement of the John Walker Moore Foundation Drive was approved and the Council concurred in the recommendation of the McDowell Memorial Foundation and the recommendation of the Executive Committee that the Foundation be dissolved. A committee to present the pros and cons of expanding medical education facilities in Kentucky in the form of an article for the Journal was authorized, and the Council endorsed the request of the Board of Health to exercise powers granted it by the 1952 Medical Practice Act to broaden the issuance of limited licenses. A recommendation that a physician in active practice be employed to serve as assistant scientific editor of the Journal was approved, and procedure for returning rejected scientific papers was voted.

The fourth meeting of the Council was held May 21, 1953. This was a called meeting for the purpose of filling the office of president which was made vacant through the passing of R. Haynes Barr, M.D., of Owensboro, on May 5, 1953. Procedure for choosing a president as provided for in the By-Laws was read to the Council. Following the vote it was announced that G. Y. Graves, M.D., Bowling Green, vice-president from the western district, had been elected.

The fifth meeting was held August 6, 1953. The recommendation of the Public Health Committee and the Executive Committee that an immunization week be held in Kentucky was approved. The recommendation of the Education Campaign Committee and the Legislative Committee that the pamphlet "Science vs. Chiropractic" be sent to every physician in the state and that the expense of sending this pamphlet be charged to the Legislative Committee account was approved. The recommendation that a permanent Insurance Committee be set up was voted, and the chairman of the Council was authorized to send an explanatory letter of the Association's financial position to each member of the House of Delegates before the Annual Meeting. The Council took notice of the passing of Elmer L. Henderson, M.D., of Louisville, and adopted a resolution which it authorized sent to Doctor Henderson's family, the A.M.A. and printed in the Journal.

Following careful study, the Council authorized the appointment of a committee to study the matter of admitting colored physicians to membership in the Association and voted to leave its position unchanged on the matter of expanding medical education facilities in the state. The activation of a Committee on Veterans Medical Care was authorized.

The three recommendations of the Council to the House of Delegates were:

Awards

"The Association offers two awards each year—the Distinguished Service Award and the Outstanding General Practitioner Award. It is the established practice of the Association that the Council refer to the House three nominations for each award.

This information concerning these awards has been publicized in the Journal, in the Secretary's Letter and by direct communication with the secretary of each county medical society. In spite of this, your Council has received only one nomination for each award, and therefore cannot fulfill its expected role, so we feel that we should pass this information to the House of Delegates and should you desire to place nominations from the floor, the Council will then place in nomination the names submitted for it."

Membership Changes

"Your Council since the last Annual Meeting has spent considerable time in the study of the problem referrable to the admission of colored physicians to membership in the Kentucky State Medical Association and is acutely aware of the ramifications connected with its solution.

A special committee has been appointed to study this problem and make a report to the Council giving it additional information. This committee has set as a date for the completion of its work February 15, 1954.

The Council recommends to the House of Delegates that action on the acceptance of colored physicians be deferred until this committee has made its report and the Council has

further opportunity to study this problem and present a recommendation to the House of Delegates."

Annual Dues

"In order to maintain the services and programs of the Kentucky State Medical Association that have been approved by the House of Delegates at the present level, the Association will, with its present income, deficit spend during this fiscal year to the extent of $13,000.

Your Council has made a thorough study of our financial structure with states of comparable size and is extremely reluctant to continue deficit spending.

In order to balance our budget and to gradually build up over a period of years our reserves to what is considered an adequate level, the Council recommends that our annual dues be increased from $25 to $35 per annum."

Reference Committee No. 1 next considered the report and recommendations of the Council. There was extensive discussion of this report and the Committee unanimously urges its adoption.

The Committee further recommends, in regard to the Distinguished Service and Outstanding General Practitioner Awards, that in the event the names of three candidates are not submitted to the Council for an award, the award not be given for that year.

The Committee recommends adoption of this section of its report.

Motion was made, seconded and carried that the report of the Council be adopted.

Report of the Secretary and General Manager

The secretary and general manager commented on the tremendous volume of work being handled by the Headquarters Office in carrying out the policies and programs of the Association. He told of the work being done by the numerous committees of the Association, especially the committees supervising the Annual Meeting. Other highlights of the report included the County Society Officers Conference, the Rural Health Movement, publications of the Association and various other activities. He thanked the officers and committees for the time and work so generously given and expressed appreciation to Mr. Vincent Goodlett, Association attorney, and the Headquarters Staff.

The Committee next received the Report of the Secretary and General Manager which was approved with thanks for the effective service of Dr. Underwood.

It is recommended that this section of the Committee's report be adopted.

Motion was made, seconded and carried that the Report of the Secretary and General Manager be adopted.

Report of the Editor

The Editor reported the appointment of Jack Chumley, M.D., Louisville, as associate editor in charge of the Scientific Section of the Journal, and stated the Journal is making progress toward its goal of being among the best in its population class. He stated that advertising rates had been increased and that the December issue of the Journal would carry only a brief digest of reports to the House instead of verbatim reports due to the expense involved. He told of the resignation of Mr. R. F. Dixon from the Journal due to other pressing duties and said his responsibilities have been transferred to Mr. J. P. Sanford.

Receipts and costs involved in printing the Journal were given and the Editor expressed appreciation to the Editorial Advisory Committee, the Board of Consultants on Scientific Articles, the publishers and the Headquarters Staff.

The Committee next received the Report of the Editor of the Journal of the K.S.M.A. It recommends the adoption of this section of its report.

Motion was made, seconded and carried that the report of the Editor be adopted.

Report of the Treasurer

The report of the Treasurer contained the recent Audit of the Association's financial situation with statement of financial condition and statement of income and expenses for the Fiscal Year ending June 30, 1953.

The Committee next reviewed the Report of the Treasurer and the auditors' statement. It wishes to express appreciation to Dr. Troutman for his services and recommend adoption of this section of its report.

Motion was made, seconded and carried that the Report of the Treasurer be adopted.

Reports of A.M.A. Delegates to the Denver Session, Washington Session, New York Session

The A.M.A. Delegate to the Denver Session reported the subjects of interest discussed included the problem of nursing, internships and non-service medical care at Veterans Administration Hospital, which was disapproved by the majority of delegates but tabled for future consideration.

The Delegate to the Washington Session discussed the elevation of the Federal Security Agency to Cabinet status and changing the name to the Department of Health, Education and Welfare. He said that an assistant will be appointed to the Secretary who is a recognized leader in the medical field with non-governmental experience. The A.M.A. Board of Trustees recommended that the House of Delegates reaffirm the A.M.A.'s stand for an independent Department of Health, but support the present plan "as a step in the right direction."

The Delegates to the New York Session reported that Walter B. Martin of Norfolk, Virginia, has been named as president-elect of the A.M.A., and that Edward J. McCormick of Toledo, Ohio, had taken office as president. The A.M.A. House of Delegates adopted the policy that treatment of non-service connected

disabilities by the Veterans Administration should be discontinued except in cases involving tuberculosis, psychiatric or neurological disorders. The House reaffirmed the supremacy of the A.M.A. code of ethics and urged that the Judicial Council study suggested revisions concerning methods of billing. Action was deferred until the June, 1954, meeting on the report of the Committee for the Study of Relations between Osteopathy and Medicine. Other actions taken concerned internship programs, international treaties and election of officers.

The Committee next received the Reports of the K.S.M.A.'s Delegates to the American Medical Association for the Denver Meeting, the special Washington Meeting, and the Annual New York Meeting of the House of Delegates of the American Medical Association.

The Committee wishes to express our appreciation for the competent representation by our delegates and moves adoption of this section of its report.

Motion was made, seconded and carried that the reports of the A.M.A. Delegates be adopted.

The Committee now wishes to move the adoption of its report as a whole.

Motion was made, seconded and carried that the Report of Reference Committee No. 1 be adopted.

Reference Committee No. 1

E. M. Howard, M.D., Harlan, Chairman
Lawrence T. Minish, Jr., M.D., Louisville, Vice-Chairman
C. F. Long, M.D., Elizabethtown
Wendell V. Lyon, M.D., Ashland
William R. McCormack, M.D., Bowling Green

Reference Committee No. 2

W. Vinson Pierce, M.D., Chairman

(Reports on Medical Care, Medical Education, Hospitals and Related Subjects)

Report of the Pharmacy Committee

The Pharmacy Committee had investigated one instance of advertisements in poor taste.

No legal action was necessary on the part of the Pharmacy Committee last year. In one instance, the Committee took steps to correct a bit of advertising which was in poor taste.

Mr. Speaker, I move the adoption of the report as a whole.

Motion was made, seconded and carried that the report of the Pharmacy Committee be adopted.

Report of the Advisory Committee on Blood Banks

No meeting of the Committee was held since no problems or requests were referred to it.

The Advisory Committee on Blood Banks feels that integration of community banks on a statewide level is a project to be considered during the coming year.

Mr. Speaker, I move the adoption of the report as a whole.

Motion was made, seconded and carried that the report of the Committee on Blood Banks be adopted.

Report of Committee on Scientific Exhibits

The Committee has increased the number of scientific exhibits at the Annual Meeting to fifteen.

The Committee has arranged for fifteen exhibits at the Annual Meeting this year, which is an increase of four.

This Reference Committee wishes to commend the Committee on Scientific Exhibits for their efforts in arranging this excellent group of exhibits.

Mr. Speaker, I move the adoption of the report as a whole.

Motion was made, seconded and carried that the report of the Committee on Scientific Exhibits be adopted.

Report of K.S.M.A Dental Committee

Representatives of the Medical and Dental Associations had held a joint meeting, at which time the K.S.D.A. representatives said the Dental Association had voted to adopt the K.S.M.A. recommendations.

The joint meeting of the liaison committees of the K.S.M.A. and K.S.D.A., which was mentioned in the report, should result in a better mutual understanding between the members of the two professions. The delegates of the K.S.D.A. voted to adopt several of the recommendations of the K.S.M.A. These recommendations will be sent to all county medical society secretaries.

Mr. Speaker, I move the adoption of the report as a whole.

Motion was made, seconded and carried that the Report of the K.S.M.A. Dental Committee be adopted.

Report of Advisory Committee on Mental Hygiene and Mental Institutions

Specific points in the report included the creation of a new Department of Mental Health as of July 1, 1952, an Advisory Council to the Department of Mental Health, staffing mental institutions, and transferral of the Division of Mental Hygiene of the State Health Department to the Department of Mental Health and funds allotted for the Department.

The report calls attention to the creation by the Governor and Legislature of a new Department of Mental Health, which went

into effect in July, 1952, and of the organization of a consulting staff to assist this Department. There was also created an Advisory Council of Mental Health which includes the Commissioner of Health and twelve members, including physicians, psychiatrists and laymen, appointed by the Governor.

Two new superintendents of our state hospitals have been appointed, both of whom are trained psychiatrists. The medical and nursing staffs of all the hospitals have been increased.

The Division of Mental Hygiene has been transferred to the Department of Mental Health.

The Committee on Mental Hygiene and Mental Hospitals feels that an increase in the funds allocated to this Department is desperately needed. The estimated current year's allowance of $5,375,512 is far short of the actual needs.

Changes in the Commitment Laws are being studied.

Mr. Speaker, I move the adoption of the report as a whole.

Motion was made, seconded and carried that the Report of the Committee on Mental Hygiene and Mental Institutions be adopted.

Report of Committee on Medical Education

The report concerned itself with the development of the Telephone Seminar series for 1953.

Taylor County Medical Society Resolution

"WHEREAS, the Taylor County Medical Society would like to bring to the attention of the Committee on Post Graduate Study the following items for consideration.

1. The Telephone Seminars have been of much value, and have contained information very helpful to the members of our Association.
2. The reception of these discussions have at times been faulty to the point that less than half of the words could be understood, and the meaning therefore lost.
3. The time of the program may be such that there is a conflict with another event in the local communities.
4. Telephone systems in portions of the State are such that hookups are not always possible.
5. It is recommended that the Committee consider the making of tape recordings of the Seminars in the future, for distribution to medical groups on request.
   a. Expense would be reduced.
   b. The programs would be available to many more groups.
   c. Reception will be improved in many localities.
   d. Restudy of interesting features would be possible."

The Committee on Medical Education was a report of the 1953 Kentucky Medical Association Telephone Postgraduate Medical Seminars and Reference Committee No. 2 wishes to commend the Medical Committee for the Telephone Seminar. It is the opinion of this Committee that serious consideration should be given to the Taylor County Medical Society resolution that, in the future, tape recordings be used instead of Telephone Seminars.

Mr. Speaker, I move the adoption of the report as a whole.

Motion was made, seconded and carried that the Report of the Committee on Medical Education be adopted.

Report of the Advisory Committee on Public Health

Highlights of the report included studying the utilization of non-professionally trained personnel by health department units; supervision of local health departments by trained laymen or nurses; and an immunization week in Kentucky.

A meeting was held at Mammoth Cave National Park Hotel, June 7, 1953.

The Committee makes the following suggestions:

1. The study of utilization of non-professionally trained personnel by health department units, especially using practical nurses and people the units can train.
2. Local health departments be supervised by well trained laymen or nurses.
3. Set up in Kentucky an annual immunization week supported fully by the K.S.M.A. to take place the first week in May each year. This latter is strongly recommended.

Reference Committee No. 2 recommends further study of the problems of health department personnel and supervisors and endorses the immunization week.

Mr. Speaker, I move the adoption of the report as amended.

Motion was made, seconded and carried that the Report of the Committee on Public Health be adopted as amended.

Report of Medical School Advisory Committee and Supplemental Report

The report recommends that the Dean's office circulate a letter or pamphlet several times during the year informing the profession on items of interest at the school, that a full-time representative of the faculty attend all sectional state meetings and the placement of second and third year medical students under preceptorships.

The Committee recommends continued support to the Medical School. It suggests that the Dean's office publish a circular letter or pamphlet several times during the school year, containing items of interest about the work in progress at the school. It was also suggested that a full time representative of the faculty attend

sectional and state meetings to develop "good will" through personal contact with local physicians. It was also recommended that second and third year medical students work during the summer in the hospitals of Kentucky or under preceptorships.

Mr. Speaker, I move the adoption of the report as a whole.

Motion was made, seconded and carried that the Report of the Medical School Advisory Committee be adopted.

Report of Advisory Committee on General Practice

No requests for action had been made to the committee.

There were no requests for action by this committee.

Mr. Speaker, I move the adoption of the report as a whole.

Motion was made, seconded and carried that the Report of the Committee on General Practice be adopted.

Report of Advisory Committee on Physical Therapy

Three young persons have been encouraged to train for physical therapy.

There has been no activity by the Committee. Three young people have been encouraged to train for physical therapy.

Mr. Speaker, I move the adoption of the report as a whole.

Motion was made, seconded and carried that the Report of the Advisory Committee on Physical Therapy be adopted.

Report of the Kentucky Committee for Contributions to American Medical Education Foundation

Funds will be actively sought this year and plans are being made to have Medical School alumni contributions routed through the committee.

The Committee will make active solicitation for funds this year. Contributions of alumni of the University of Louisville School of Medicine are planned to go through this Committee and be credited to the Foundation.

Mr. Speaker, I move the adoption of the report as a whole.

Motion was made, seconded and carried that the Report of the Committee be adopted.

Report of the Member of the Advisory Council to University of Louisville Medical School, Student A.M.A. Chapter

The Student A.M.A. Chapter has a membership of 50% of the student body, or 200 members. Its functions center about distribution of the Journal, conducting regular programs and committee action in an advisory capacity.

The Louisville Chapter of the Student A.M.A. has a membership of 200 students.

The function of the local chapter is centered about:

1. Distribution of the Journal.
2. Conducting regular programs.
3. Committee action in an advisory capacity.

The Chapter looks forward to continued growth and usefulness.

Mr. Speaker, I move the adoption of the report as a whole.

Motion was made, seconded and carried that the report of the Advisor be adopted.

Report of the Committee on Corporate Practice of Medicine

The committee reports there are many problems to be considered.

Mr. Speaker, I move the adoption of the report as a whole, and that the committee be continued.

Motion was made, seconded and carried that the Report of the Committee on Corporate Practice of Medicine be adopted.

Report of Committee on Nurse Training

No actions were taken by the committee.

No matters were referred to this Committee during the past year.

Mr. Speaker, I move the adoption of the report as a whole.

Motion was made, seconded and carried that the report of the Committee on Nurse Training be adopted.

Report of the Insurance Committee

The committee studied various proposals made by the Fayette County Medical Society, including formation of a permanent insurance committee, development of a uniform claim blank to report health, accident and hospital claims and the issuance of a pamphlet for lay use in clarifying insurance coverage.

Report of the Insurance Committee proposed that a permanent committee of five members, to serve not more than five years or less than one year, be established to consider all health and accident insurance matters that might be presented to it and that terms of office be staggered so as to insure continuity of the committee. The committee voted to pass all information and material which they had on hand to the new committee.

Reference Committee No. 2 concurs in this and recommends that the committee be accomplished.

Mr. Speaker, I move the adoption of the report as a whole.

Motion was made, seconded and carried that the Report of the Insurance Committee be adopted.

Report of Advisory Committee on Industrial Medicine and Surgery

The committee is cooperating with the Council on Industrial Health of the A.M.A. in planning for an industrial meeting in the South to be held in Louisville February, 1954.

The Committee is cooperating with the Council of Industrial Health of the A.M.A. preparing for the industrial meeting in the South to be in Louisville, February, 1954. This is in recognition of the Growth of Industry and Industrial Medicine in the South.

Mr. Speaker, I move the adoption of the report as a whole.

Motion was made, seconded and carried that the Report of the Committee on Industrial Medicine and Surgery be adopted.

Report of Advisory Committee on Crippled Children

While no business was referred to the committee by the Association the report took notice of a conference to be held for the study of handicapped children of the state of Kentucky and the allocation of funds by a voluntary organization to the director of the State Department of Health for treatment of specific conditions at his discretion.

The fact that a conference for the study of handicapped children of Kentucky will be held in Louisville October 22 and 23, 1953, is worthy of emphasis.

An adverse report of this committee concerning the process whereby a voluntary organization, interested in the care of children with certain specific crippling conditions, has allocated money to the director of the State Department of Health for treatment of these specific conditions at his discretion, is especially noteworthy.

It is the feeling of this Advisory Committee that such a procedure is another step along the line of the state practice of medicine and is not in the best interests of the practice of medicine by the physicians of the state, nor in the best interests of harmony between the State Board of Health and the members of the Kentucky State Medical Association. It is suggested by this committee that this matter be further investigated and openly discussed by the delegates or discussed at the meeting of the State Medical Association.

This Reference Committee suggests that these funds be held by the Crippled Children Commission or some other agency for the care of indigent children only.

Mr. Speaker, I move the adoption of the report as a whole.

Motion was made, seconded and carried that the Report of the Committee on Crippled Children be adopted.

Report of Committee on Hospitals

The report concerned a resolution received from the Blair County Medical Society of Altoona, Pennsylvania, dealing with changes in essentials for approval for internships.

A letter was received from the Blair County Medical Society of Altoona, Pennsylvania, asking opposition to a resolution for approval of internships by the Advisory Committee on Approved Internships of the Council of Medical Education and Hospitals of the A.M.A.

These changes were:

1. Increase in the bed capacity, including bassinets, to 150.

2. Increase in annual admissions, excluding bassinets, to 5000.

3. Autopsy required rate raised to 25%.

4. Continued approval dependent on the hospital obtaining at least two-thirds of its normal complement of interns.

The Committee considered the changes were made in an attempt to insure reasonably well-rounded training for interns and recommended that the K.S.M.A. take no action on the Blair County letter.

Reference Committee No. 2 disagrees with the recommendations of the Committee on Hospitals in their action on the Blair County letter. The Committee feels that the entire resolution for approval of internships of the Council of Medical Education and Hospitals of the A.M.A., as reported in the Journal of the American Medical Association, should be reviewed and that our delegates to the A.M.A. shall be instructed to fight for its modification so that the majority of hospitals now approved for internship may continue to be approved for internships.

Motion was made, seconded and carried that the Report of the Committee on Hospitals be adopted.

Report of Committee on Medical Service and Supplemental Report

The reports concerned the survey on indigent medical care being made by K.S.M.A. and the A.M.A. in a selected group of counties in the state and through statewide organizations taking part in providing medical care for the indigent.

We recommend acceptance of this Committee's report as read and wish to urge that members of the Association cooperate

fully with this effort to study the magnitude of the indigent medical care problem in Kentucky.

Motion was made, seconded and carried that the report of the Committee on Medical Service be adopted.

Report on Medical Research Commission

The contract with the Medical School of the University of Louisville for research, paying the school $200,000 for research yearly, has been continued.

We recommend acceptance of this report as read. The fact that this Commission has been a means of transferring $200,000 for research yearly to the only medical school in the state is worthy of note.

Report of Advisory Committee on Pediatrics

The report contained the recommendation of the committee for the allocation of gamma globulin for the control of measles, hepatitis and poliomyelitis, and that the Health Department keep records of the allocation in an attempt to determine the effect of the substance on the spread of poliomyelitis.

We recommend acceptance of this report and wish to call attention of the delegates to the work done by this group on the allocation and distribution of gamma globulin.

Motion was made, seconded and carried that the Report of the Committee on Pediatrics be adopted.

Report of Advisory Committee on Cancer

No business was referred to the committee.

The report of the Advisory Committee on Cancer was read and approved as read, since no business was referred to this committee during the 1952-53 year for consideration, although the committee had five regular monthly meetings, all of which were well attended.

Mr. Speaker, I move the adoption of the report as a whole.

Motion was made, seconded and carried that the Report of the Committee on Cancer be adopted.

Report of the Committee on Scientific Assembly

The report was a digest of the plans for the Annual Meeting.

Mr. Speaker, I move the adoption of this report as a whole.

Motion was made, seconded and carried that the Report of the Committee on Scientific Assembly be adopted.

Report of Diabetes Committee

The report discussed the results of the 1952 Diabetes Detection Drive and plans for the 1953 Drive.

The report of the Diabetes Committee shows that public interest in diabetes increased over 100% from 1951 to 1952 in the number of urine sugars examined and the number of new diabetes cases discovered. This interest is due in a large part to the drive put on by the radio, television and press in the 62 counties reporting this year as to the 32 counties last year. Again we publicly thank the Ames Company of Elkhart, Indiana, for donating the clinitest tablets throughout the state for the urine sugar tests.

Mr. Speaker, I move the adoption of the report as a whole.

Motion was made, seconded and carried that the report of the Diabetes Committee be adopted.

Report of the Committee on Technical Exhibits

The report discussed the promotion of technical exhibits at the annual meeting.

The report of the Committee on Technical Exhibits was approved as read and it is very gratifying to know that 60 exhibitors feel that the Kentucky State Medical Association's meeting is one of the best among the smaller associations. This Committee wishes to congratulate the Journal, the Secretary's Letter, News Capsules and other direct mail for their information of the contributions the exhibitors make to our meeting as well as congratulate the exhibitors for a big job well done.

Mr. Speaker, I move the adoption of the report as a whole.

Motion was made, seconded and carried that the Report of the Committee on Technical Exhibits be adopted.

Report of Advisory Committee on Obstetrics

No business had been referred to the Committee, but the Committee did make five suggestions which are listed in the Reference Committee report.

The report of the Advisory Committee on Obstetrics was approved as read with emphasis on the five objectives or goals of

1. Reduction of the mortality and morbidity in mothers.
2. An expected survival rate of babies
3. Incidence of toxemia
4. Obstetrical Anesthesia
5. A correlation of work between our State Association and the Kentucky State O.B. and Gyn. Societies

Mr. Speaker, I move the adoption of the report as a whole.

Motion was made, seconded and carried that the report of the Committee on Obstetrics be adopted.

Report of the Advisory Committee on Tuberculosis

The report discussed an act by the General Assembly relating to state tuberculosis hospitals and the State Tuberculosis Hospital Commission and recommended its approval.

It is the recommendation of the Committee that the K.S.M.A. approve:

(1) Adoption by the Kentucky State Legislature of an act relating to state tuberculosis hospitals and the State Tuberculosis Hospital Commission, which act is being sponsored by the Kentucky Coordinating Council and reads as follows:

An act relating to state tuberculosis hospitals and the State Tuberculosis Hospital Commission.

The act provides that the state be divided into districts, one for each state TB hospital, these to be under a commission consisting of six members: the Commissioner of Welfare and Commissioner of Health to be ex-officio and the other four to two doctors of medicine and two lay members. The Council names three doctors from which two are named by the Governor.

This Commission meets regularly as deemed necessary and elects a chairman and other officers annually. Those members other than ex-officio receive $10.00 per diem and travel expenses.

The Commission has full charge of government of these districts subject to Chapter 12, 41, 42, and 45 and it shall furnish to the Governor annually its report.

The Commission shall name an executive director who resides in Frankfort and he shall be authorized to employ personnel of each hospital and be responsible to the Commission for total administration.

The Commission may have authority for waiting list and transfer of patients as seem fit.

Mr. Speaker, I move the adoption of the report as a whole.

Motion was made, seconded and carried that the Report of the Committee on Tuberculosis be adopted.

Report of Advisory Committee to the Editor

Many changes have been put into effect including advertising material, rates and matters regarding publication.

We approve the report of this Committee as read and wish to commend them for their recent changes in the Journal of the Association.

Constructive criticism by members of the Association should be helpful in improving this publication.

Mr. Speaker, I move the adoption of this report as a whole.

Motion was made, seconded and carried that the Report of the Advisory Committee to the Editor be adopted.

Report of Committee for Special Article on Medical Education

The report of this Committee appeared in the September issue of the Journal of K.S.M.A. and was read before the House at its first session, September 21. The Reference Committee made two reports, a majority and a minority report covering the special article. The minority report was read first.

Minority Report

The best possible medical care for the people of Kentucky should be the object of the organized physicians of the state. Any goal below the optimum must not be considered in the overall planning of the K.S.M.A. The future of medical education is of vital importance to every citizen of the Commonwealth and is not a matter to be treated lightly or cavalierly. No man can foresee the future, but in any long range planning certain trends are apparent which may guide the planners. In this case they are as diverse as population increase or decrease, industrial development, fiscal policy, tax structure and the need and utilization of the individual physician. Such a problem needs deep study of all these factors and the mature thought and effort of the best medical brains in the state to make a blue print of the future. We may find that these plans are impossible of accomplishment but our efforts are more likely to result in solid advancement than if we consider "that everything is for the best in this best of worlds" and are content to preserve the status quo.

I feel that the Report of the Special Committee on Medical Education oversimplifies a very complex problem and must be considered only as a preliminary statement. I recommend that a new committee be appointed to exhaustively consider this matter and to report to the Association a summary of its findings and conclusions. Since this matter in the past has been distorted by the civic and collegiate partisanship, I respectfully suggest to the House of Delegates that a new committee be appointed and that the members of this new committee be physicians from all parts of the state, exclusive of Louisville and Lexington, who are graduates of out-of-the-state medical schools.

Respectfully submitted,
Richard G. Elliott, M.D., Lexington

Majority Report

Reference Committee No. 2 has studied the article on medical education as printed in the

Journal of K.S.M.A. for September 1953 and has considered the viewpoints presented in both the majority and minority reports. It is the opinion of this Committee that the subject under consideration requires considerable further study before definite opinions can be reached.

The Reference Committee recommends that such further study be carried out and that no recommendation for action be made to the House of Delegates at this time.

Ward Bushart, M.D.
Chris Jackson, M.D.
Garnett J. Sweeney, M.D.
W. Vinson Pierce, M.D.

Mr. Speaker, I move the report be accepted as amended by the majority report of the Reference Committee.

Motion was seconded and carried that the report of Reference Committee No. 2 be adopted.

Mr. Speaker, I move the adoption of the report of Reference Committee No. 2 as a whole.

Motion was seconded and carried that the report of Reference Committee No. 2 be adopted.

Reference Committee No. 2

W. Vinson Pierce, M.D., Covington, Chairman
Richard G. Elliott, M.D., Lexington, Vice-Chairman
Ward Bushart, M.D., Fulton
Chris Jackson, M.D., Danville
Garnett J. Sweeney, M.D., Liberty

Reference Committee No. 3

Richard J. Rust, M.D., Chairman
(Reports on Legislation and Public Relations)

Public Relations Committee

Committee representatives participated in regional and state meetings on behalf of the Association dealing with PR problems of interest to the K.S.M.A. Also, the Committee dispersed material to the members of the Association during the year on PR matters.

It is the recommendation of this Reference Committee that the report of the Public Relations Committee be accepted with thanks.

Mr. Speaker, I move the adoption of this report as a whole.

Motion was seconded and carried that the report of the Public Relations Committee be adopted.

Committee to Study the Constitution and By-Laws

The report concerned recommendations for changes in the By-Laws of K.S.M.A. for the 1953-54 year, which were listed in the Reference Committee report below.

This Reference Committee recommends the following action on the report of the Committee to Study the Constitution and By-Laws be taken.

1. In Chapter III, in the last sentence and in Chapter IV, Section 1, in the first sentence, delete "and the annual orations" with the recommendation that this deletion be effective with the 1955 session since the present nominees for orators in both medicine and surgery have already been made by the Nominating Committee for the year 1954.

Mr. Speaker, I move the adoption of this section of the report.

Motion was seconded and carried that this section of the report be adopted.

2. It is recommended that Chapter IV, Section 17, be made to delete the first two words "The complete" and substitute "A digest of the proceedings of the House of Delegates shall be published in the Journal of the Association."

Mr. Speaker, I move the adoption of this section of the report.

Motion was seconded and carried that this section of the report be adopted.

3. It is recommended that in Chapter VII, Section 3, delete in its entirety the third sentence concerning the duties of the councilor reading, "He shall make an annual report of his doings, and of the condition of the profession of each county in his district to each Annual Session of the House of Delegates."

Mr. Speaker, I move the adoption of this section of the report.

Motion was seconded and carried that this section of the report be adopted.

4. It is recommended by this Reference Committee that under Chapter VII of the By-Laws of this Association an additional section which shall henceforth be known as Section 9 be appended to this chapter. This section shall read as follows:

"In the event the office of one of the District Councilors is vacated between meetings of the House of Delegates, the president of the Association may call a meeting of the delegates of record in the Headquarters Office from the counties of that district for the purpose of submitting one or more nominees as candidates to fill the office until the next meeting of the House of Delegates. The name or names of the nominee or nominees shall be submitted to the Council, which will elect a Councilor from them to serve until the next meeting of the House of Delegates."

Mr. Speaker, I move the adoption of this section of the report.

Motion was seconded and carried that

this section of the report be adopted.

5. It is recommended by this Committee that in Chapter VIII, Section 1, the last sentence be changed to read, as follows: "The president, secretary and general manager, and executive secretary shall be ex-officio members of all committees, serving without power to vote except as otherwise specified."

Mr. Speaker, I move the adoption of this section of the report.

Motion was seconded and carried that this section of the report be adopted.

6. It is recommended that in Chapter VIII, Section 3, of the By-Laws of the Kentucky State Medical Association the fourth sentence which is "The Secretary of the Association shall be a member and Secretary of the Committee," be deleted and that the fifth sentence be made to read "The President of the Association shall appoint one member each year for a three-year term."

It is also recommended that in Chapter VI, Section 7, fourth from the last sentence of the first paragraph of Section 7, the entire sentence be deleted which reads, "He shall act as secretary of the Committee on Scientific Assembly."

Mr. Speaker, I move the adoption of this section of the report.

Motion was seconded and carried that the section of the report be adopted.

Mr. Speaker, I move the adoption of this report as amended.

Motion was seconded and carried that the report be adopted as amended.

Medico-Legal Committee

The Committee reported that professional liability claims in Kentucky have been on the decrease and in the past 12 months no case has come to trial and only three cases have been terminated by compromise. Accidents directly from or connected with anesthesia lead the list of claims.

Mr. Speaker, I move the adoption of this report together with its supplemental report as a whole.

Motion was seconded and carried that the report of the Medico-Legal Committee be adopted.

Education Campaign Committee

The report called attention to the following projects of the Committee: KSMA News Capsules, a monthly information sheet, distribution of A.M.A. pamphlets to the public through doctors' offices, showing the films, "Without Fear" and "Your Doctor," placing broadcasts prepared by the A.M.A., an exhibit at the Kentucky State Fair, a public relations course for doctors' secretaries and the inclusion of a group of lectures on medical economics and public relations for senior medical students. The report also discussed plans for future activities.

It is the recommendation of Reference Committee No. 3 that the report of this committee be approved with the highest commendation for the excellent work they have accomplished in the past year. It is also felt by this Reference Committee that special attention should be given of the House of Delegates to the following recommendations:

1. That the Education Campaign Committee continue and expand its "News Capsules."

2. That the lay radio programs be continued and expanded as far as possible.

3. That the delegates from the various county societies return to their constituent societies to encourage them in the making of arrangements for the secretary's course as is being proposed by this committee.

4. That the county societies discuss among themselves and return a report of the feeling of the various societies throughout the state concerning the adoption of a press-radio medical code for the society.

Mr. Speaker, I move the adoption of the report as a whole.

Motion was seconded and carried that the report of the Education Campaign Committee be adopted.

Legislative Committee

The committee had a light year since there was no meeting of the General Assembly in 1953. However, it participated actively in the primary election held in August.

It is recommended by Reference Committee No. 3 that the Report of the Legislative Committee be approved in its entirety with thanks to the members of the committee for their efforts.

Mr. Speaker, I move the adoption of this report as a whole.

Motion was seconded and carried that the Report of the Legislative Committee be adopted.

Committee to Study the Medical Examiner System

The committee requested that the House of Delegates reaffirm its previous stand in favor of a Medical Examiner System and asked that a careful study be made of the shortcomings of the Coroner System and recommend to the Legislature such proposals as may be appropriate to rectify them.

It is recommended that the report of the Committee to Study the Medical Examiner System be accepted with thanks with the recommendation that the Legislative

Committee of the Kentucky State Medical Association study this problem carefully with the view to proposing legislation adequate for the needs of the state of Kentucky to the next General Assembly of the State of Kentucky.

Mr. Speaker, I move the adoption of this report as a whole.

Motion was seconded and carried that the report of the Committee to Study the Medical Examiner System be adopted.

Professional Relations Committee

The committee had handled fourteen cases in which patients had brought charges of various kinds against members of the Association in the past year.

It is recommended by this Reference Committee that the report of the Professional Relations Committee be adopted in its entirety with thanks.

Mr. Speaker I move the adoption of this report as a whole.

Motion was seconded and carried that the report of the Professional Relations Committee be adopted.

Committee on the United Mine Workers Health and Welfare Fund

Highlights of the United Mine Workers of America Welfare and Retirement Fund report were:

1. That the K.S.M.A. Hospital Committee set up a hospital consulting service which would be available on the request of hospital management for the purpose of advising with the hospital concerning plant, equipment, organization and management. The consultant service is in no way to be regarded as an organization to rate hospitals.
2. Home and office care. Any County Medical Society wishing to undertake a program of prepaid home and office care within its territory shall present to the Council of the K.S.M.A. a prospectus of its proposed plan. If the plan is ethical, financially reasonable and subscribed to by a majority of the members of the County Medical Society, the KSMA, acting through the Council shall give its endorsement and encouragement.
3. That the Committee on Medical Education of the Association cooperate in the manner of establishing postgraduate programs of study on maintaining the system of fee-for-service and free choice of physicians.

It is recommended that the report of the Advisory Committee on the United Mine Workers Health and Welfare Fund be approved in its entirety with the following specific recommendations, namely:

1. That the Committee on Hospitals of the Kentucky State Medical Association consider the feasibility of organizing a consulting service consisting of hospital administrators, record librarians, and representatives of the medical profession to be available to the smaller hospitals throughout Kentucky on the request of the hospital management to study the problem of that hospital and advise concerning plant, equipment, organization and management. It is intended that this be an advisory board and not a standardizing or rating board.

Mr. Speaker, I move the adoption of this section of the report.

Motion was seconded and carried that this section of the report be adopted.

2. It is further recommended that the House of Delegates approve the recommendation of this committee to enable any county medical society to undertake a program of prepaid home and office care if such program is found to be ethical and financially sound and if it is subscribed to by the majority of the members of the county medical society.

Mr. Speaker, I move the adoption of this section of the report.

Motion was seconded and carried that this section of the report be adopted.

Mr. Speaker, I move the adoption of the report as a whole.

Motion was seconded and carried that the report of the Committee on United Mine Workers Health and Welfare Fund be adopted.

Board of Trustees of the Rural Kentucky Medical Scholarship Fund

The report discussed the medical students being helped by the Fund and the financial status of the Fund.

It is recommended (1) that the report of this committee be accepted with thanks, (2) it is further recommended that the House of Delegates approve the establishment of an additional full scholarship providing the finances of the Association will permit, and (3) that this Association endorse the request of the committee for personal contributions by physicians to this scholarship fund.

Mr. Speaker, I move the adoption of the report as a whole.

Motion was seconded and carried that the report of the Board of Trustees of the Rural Kentucky Medical Scholarship Fund be adopted.

Conference of Presidents and Other Officers of State Medical Associations

The report discussed the meeting of the Conference which the President had attended.

It is recommended by this committee that this report be accepted with thanks.

Mr. Speaker, I move the adoption of this report as a whole.

Motion was seconded and carried the report be adopted.

Reference Committee No. 3

Richard J. Rust, M.D., Newport, Chairman
Gradie R. Rowntree, M.D., Louisville, Vice-Chairman
Carl Fortune, M.D., Lexington
B. Ralph Wilson, M.D., Sharpsburg
Ralph D. Lynn, M.D., Elkton

Reference Committee No. 4

T. O. Meredith, M.D., Chairman

(Reports on Miscellaneous Business)

Advisory Committee to Selective Service

The report discussed the calling into service of physicians and said that while the "draft law" has been extended it is not expected that any physicians will be called into military service for the next twelve months. Also mentioned was the change in the set-up of the committee, with the resignation of the KSMA offices.

Mr. Speaker, I move the adoption of this report as a whole.

Motion was made, seconded and carried that the report of the Advisory Committee to Selective Service be adopted.

Advisory Committee on Blue Cross

The committee has consulted with representatives of Blue Cross and Blue Shield relative to matters of policy and regarding correspondence to the members of the Association.

Mr. Speaker, I move the adoption of the report as a whole.

Motion was seconded and carried that the report of the Advisory Committee on Blue Cross be adopted.

K.S.M.A. Physicians Placement Committee

The committee reported it is seeking to broaden the existing placement service rendered in conjunction with the Division of Licensure and Registration of the Health Department and to stimulate more interest among K.S.M.A. members of medicine's obligations in seeing that there is the best possible distribution of medical care.

Mr. Speaker, I move the adoption of this report as a whole.

Motion was seconded and carried that the report be adopted.

Board of Directors of McDowell Memorial Foundation and Resolution

The report discussed the financial status of the Foundation, furnishings for the McDowell House and suggestions as to the disposition of the Apothecary Shop. The report asked that the House of Delegates continue the donation of $1500.00 for the coming year to cover repairs and supplies for the home.

This report was read at the first session of the House of Delegates.

Mr. Speaker, I move the adoption of this report as a whole.

Motion was seconded and carried that the report be adopted.

The following resolution was introduced at the first session of the House of Delegates:

"It was moved by T. O. Meredith, M.D., and seconded by Irvin Abell, M.D., that the McDowell Memorial Foundation, Inc., be dissolved and that the Chairman of the Board take or cause to be taken such steps as would be necessary and proper to accomplish the dissolution and to return to the Kentucky State Medical Association the control and operation of the McDowell Memorial Foundation, Inc., at Danville, Kentucky. In the discussion that followed, it was pointed out that at the time the corporation was formed it was hoped that sufficient contributions to the Foundation would be obtained from time to time and to be sufficient to properly operate the Memorial, but that sufficient contributions had not been received. It was further pointed out that due to the difficulty of holding meetings of the Board and obtaining a quorum at such meetings, that it would be more expedient for the House of Delegates of the Kentucky State Medical Association through a small committee to handle the affairs of the Foundation since the Association funds were required to maintain the Memorial. It was further observed that the title to the McDowell property had never passed to the corporation and had remained in the Association."

This resolution was read in its entirety at the first session of the House of Delegates.

Mr. Speaker, I move the adoption of this resolution as a whole..

Motion was seconded and carried that the resolution be adopted.

Board of Directors of Kentucky Physicians Mutual, Inc. and Supplemental Report

The report discussed the financial condition of Kentucky Physicians Mutual, Inc., and stated that the schedule of indemnities has been broadened. Future plans were also discussed. The supplemental report reported on abuses of the Mutual by some physicians.

Mr. Speaker, I move that the report of the Board of Directors of Kentucky Physicians Mutual, Inc., be adopted.

Motion was seconded and carried that the report be adopted.

We feel that the supplemental report as read to the House of Delegates at its first session needs special emphasis as it applies to every member of the medical profession in Kentucky.

Mr. Speaker, I move the adoption of this report as a whole and wish to recommend that all complaints received be referred to the Professional Relations Committee.

Motion was seconded and carried that the supplemental report be adopted.

Veterans Committee

The report discussed the treatment of non-service-connected disabilities by the Veterans Administration. The recommendations includ-

ed (1) that a liaison group be formed by the Association with veterans organizations and the public in which the Association may be able to achieve a more harmonious accord and understanding in its endeavors, and (2) that veteran members of the Association join and take an active part in veterans organizations.

Mr. Speaker, I move the adoption of this report as a whole and desire to make the following comments:

This report was read in its entirety by the chairman at the first meeting of the House of Delegates. We wish to emphasize the last paragraph which reads as follows:

"It is recommended that there be a liaison group formed by our state association with veterans organizations and the public in which we may be able to achieve a more harmonious accord and understanding in our endeavors. It is further recommended, that since about 60% of our members have been in military service, that they not only join veterans organizations but take an active part in these organizations, some of whom may have a difference of opinion on care of veterans. If this is done by our doctors, it will be much easier for the medical profession to educate the veteran groups, that our policy is the best policy for the nation as a whole."

We recommend that the president appoint a liaison committee on the state level with Daniel L. Bower, M.D., Barbourville, as chairman and further wish to commend Dr. Bower for his past invaluable services to the medical profession as a whole.

Mr. Speaker, I move the adoption of this report as a whole.

Motion was seconded and carried that the report be adopted.

The following resolution had been presented by the Taylor County Medical Society at the first session of the House.

"WHEREAS, the Taylor County Medical Society would like to bring to the attention of the Committee on Veterans Affairs the following items for consideration:

1. The rules and regulations for the admission of patients to the V. A. Hospitals are constantly changed, and subject to varied interpretation by the admitting personnel of the hospital.

2. Courtesy seems to have become a forgotten word when the V. A. Hospital is dealing with members of the Kentucky State Medical Association.

3. It is recommended that the Committee discover the present policy of the Veterans Hospital program, and inform the members of our Association concerning same through the columns of the State Medical Journal."

The Reference Committee approves paragraphs 1 and 3 and wishes to delete paragraph 2, of the resolution.

Mr. Speaker, I wish to move the adoption of the resolution as amended.

Motion was seconded and carried that the resolution be adopted as amended.

Committee to Rearrange Councilor Terms

The committee presented the plan for the rearrangement as provided by the 1952 House of Delegates and rotation of councilor terms, which was established by drawing of lots. The results of the drawing established the following plan of rotation:

Districts 1, 3, 4, 12, and 14
Districts 2, 7, 9, 10, and 13
Districts 5, 6, 8, 11, and 15

Mr. Speaker, I move the adoption of this report as a whole.

Motion was seconded and carried that the report be adopted.

Reference Committee No. 4

T. O. Meredith, M.D., Harrodsburg, Chairman
Wyatt Norvell, M.D., New Castle, Vice-Chairman
Karl D. Winter, M.D., Louisville
Frank T. Linton, M.D., Princeton
W. B. Atkinson, M.D., Campbellsville

Reference Committee No. 5

Charles B. Stacy, M.D., Chairman

(Reports on Miscellaneous Business)

Committee on School Health

The committee presented various recommendations in its report which are digested in the Reference Committee report.

The report of the Committee on School Health to the 1953 Session of the House of Delegates was personally made by Daryl P. Harvey, M.D., chairman. He reported the dates of the meetings of the committee and that the following points be observed:

1. Mechanics of the School Health Program should be worked out on a local level and each school system in Kentucky both private and public should center around a local health committee and that the health committee should involve its program around the following agencies—the family, the educators, the physicians, dentists and such public agencies as the public health department. The report stipulates that the number of members be no less than six and no more than fifteen.

2. The primary responsibility for this program should rest upon the family, and the family physician should be used in all cases except where the public health is concerned.

3. The school systems of Kentucky are primarily educational institutions and not diagnostic and health centers and again

repeating that the only health procedure that should be compulsory are those that affect the public health of the school.

4. An advisory committee from the State Medical Association should be appointed and act in this capacity to the local committees and agencies.

5. The following are the school health functions and responsibilities of the Department of Health.

a. Requirement that the immunizations should be fulfilled prior to matriculation.
b. Periodic health checks should be required as a prerequisite to matriculation, and such health examinations be worked out through the family's choice of a private physician when possible.
c. Health education should be taught in all schools and should include such subjects as sanitation, ventilation, nutrition and all phases of public health.
d. That the parents should be notified by the local school authorities of any suspected, accidental or apparent illness of the pupil and that the parents should be asked to seek the proper medical advice.
e. That the examination of all personnel employed in the school district be required.
f. The filing and keeping of health records of each pupil should be done in the schools.

This report sets forth the functions and responsibilities of the family group. It also sets forth the duty of the physician as a local practitioner in the community. It recommends that the local health committee be sponsored by the county health society wherever practical. It also recommends that every teacher should have a minimum of first aid training.

Mr. Speaker, we move the adoption of this report as a whole.

Motion was seconded and carried that the report be adopted.

Committee on Rural Health

The report discussed the Farm and Home Convention during which a discussion of the Rural Health Council Movement was held and the Second Annual Kentucky Rural Health Conference. Plans were told for the 1954 Conference.

The report of the Committee on Rural Health was received by Reference Committee No. 5. The Rural Health Committee has furthered the work in rural health in our state this year primarily through its work in connection with the Rural Health Council and in providing assistance to local health councils.

The Committee met on January 15 to make preliminary plans for the Annual Health Conference.

On February 3 the rural health council movement was held in Lexington before an audience of 2000 during a Farm and Home Convention. D. G. Miller, Jr., M.D., and John Guy Miller, Field Secretary of the K.S.M.A., participated in this program. They also attended the Eighth National Conference on Rural Health in Roanoke, Virginia.

On March 11 and 12 the Second Annual Kentucky Rural Health Conference was held at the Kentucky Hotel with an excellent program and good attendance. The voluntary cooperative rural health movement has worked very well.

On August 5 the Kentucky Rural Health Council including members from the Committee on Rural Health met in the office of the secretary and general manager. At this meeting it was decided to have further conferences later in January and February of 1954. It was generally agreed that there was plenty of work for such a council, but that there should be a clarification and amplification of its statement and functions, that more organizations should be invited to join, and a spread of activity to include more of its member organizations should be taken.

From the report it appears that the K.S.M.A. gives a sizable contribution to this activity.

Mr. .Speaker, we move the adoption of this report as a whole and recommend the continuation of this work.

Motion was seconded and carried that the report be adopted.

Committee on Arrangements

The committee worked in conjunction with the Committee on Scientific Assembly in making plans for the Annual Meeting.

Reference Committee No. 5 received the report of the Committee on Arrangements and it is apparent that most of the work of this committee was done in conjunction with the Committee on Scientific Assembly and a complete plan of the meeting as shown in the printed program.

Mr. Speaker, we move the adoption of this report as a whole.

Motion was seconded and carried that the report be adopted.

Advisory Committee to the State American Legion

The committee stated that the problem of renewing the present contract with the Veterans Administration for hometown medical care of veterans deserves early and complete study by the Veterans Committee.

Reference Committee No. 5 received the report of the Advisory Committee to the State American Legion and the only matter that had been referred to this committee was a question of renewing the present contract with the Veterans Administration for hometown medical care of veterans. The Committee felt that this problem deserves early and complete study by the new Veterans Committee and therefore the Committee recommended that the contract be renewed for a period of one year only.

Mr. Speaker, we move the adoption of this report as a whole.

Motion was seconded and carried that the report be adopted.

Committee on World Medical Association

No meeting was held of the committee.

Reference Committee No. 5 received the report of the Committee on World Medical Association. This Committee did not have a meeting during the past year; therefore no action was required of Reference Committee No. 5.

Committee on Emergency Medical Service

The report presented a minimum program for the stockpiling of supplies in event of any great disaster.

Reference Committee No. 5 received the report of the Committee on Emergency Medical Service. The report of this committee shows that it met on January 29, 1953, and that Thomas Gudex, M.D., of Louisville, acted as its chairman and in essence it is recommended that certain supplies and mobile defense units be set up through certain stations in the state of Kentucky. Meetings have been held with General Lindsay, the State Civil Defense Director. The organization of the state civil defense program and an assignment of duties have been made.

The minimum program calls for a total of supplies amounting to approximately $400,000 and is asking the cooperation of our state legislature and communities such as Paducah, Louisville and Lexington to appropriate their respective share of this amount to this program. The support of the members of the K.S.M.A. in getting this legislation passed is asked.

Mr. Speaker, we move the adoption of this recommendation and ask the support of the state organization.

Motion was seconded and carried that the report be adopted.

Advisory Committee to the Woman's Auxiliary

There was little work for the committee to do. A letter was sent to the president of the Auxiliary by the late President Haynes Barr suggesting outlines for work of the organization.

Reference Committee No. 5 received the report of the Advisory Committee to the Woman's Auxiliary. This committee had very little to do during the past year and in November a letter was forwarded to the president of the state auxiliary suggesting outlines for the work of the organization by our late President, R. Haynes Barr, M.D.

At present the organization is functioning in a normal manner.

Mr. Speaker, we move the adoption of this report as a whole.

Motion was seconded and carried that the report be adopted.

Woman's Auxiliary

The report contained a report on membership of the Auxiliary and highlights of other Auxiliary activities.

Reference Committee No. 5 received the report of the Woman's Auxiliary showing that at present they have a membership of 854 which is an increase of 46 members over one year ago.

These women do a tremendous amount of community service, particularly in the field of health and in recruiting nurses for the various scholarships, giving financial aid to nurses in training, promoting cancer publicity and by fostering certain cancer clinic work especially in Fayette and Rockcastle Counties. They have also given their support to the Blood Bank Organization, hospital assistance, raising of funds and health drives. They also sponsored subscriptions to "Today's Health" and radio programs as well as rural health and civil defense. They have assisted in the Doctors' Shop in Harrodsburg keeping this shop open for the public and getting more donations for the McDowell House. They have given their assistance in obtaining funds for the American Medical Education Foundation and made a donation of $25 to the Daviess County Memorial Medical Library in memory of Dr. R. Haynes Barr.

Its president, Mrs. David Woolfolk Bar-

(Continued on page 52)

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W. Clark Bailey, Harlan	1954
Thomas V. Gudex, 2006 Grinstead Drive, Louisville (Alternate)	1954
Bruce Underwood, 620 S. Third Street, Louisville	1955
Coleman Johnston, 211 W. Second Street, Lexington (Alternate)	1955

COUNCILORS

		Term Expires
First District	J. Vernon Pace, 109-10 Citizens Bank Bldg., Paducah	1956
Second District	Walter L. O'Nan, 237 Second St., Henderson	1955
Third District	Delmas M. Clardy, Hopkinsville	1956
Fourth District	W. Keith Crume, Bardstown	1956
Fifth District	Richard R. Slucher, Buechel	1954
Sixth District	L. O. Toomey, Bowling Green	1954
Seventh District	Branham B. Baughman, Frankfort	1955
Eighth District	Edward B. Mersch, 92 Arcadia, Covington	1954
Ninth District	J. M. Stevenson, Brooksville	1955
Tenth District	J. Farra Van Meter, 183 N. Upper St., Lexington	1955
Eleventh District	Hugh Mahaffey, Richmond	1954
Twelfth District	Garnett J. Sweeney, Liberty	1956
Thirteenth District	Charles B. Johnson, Russell	1955
Fourteenth District	John Archer, Prestonsburg	1956
Fifteenth District	Edward Wilson, Pineville	1954

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EDITORIALS

SUCCESS OR FAILURE—IT IS UP TO YOU

The past 15 or 16 years have seen a tremendous growth in the public's acceptance and use of voluntary health insurance of all types. Approximately 92,000,000 people carry policies offering them varying degrees of protection against the expense of hospitalization; more than 73,000,000 have surgical insurance, and over 36,000,000 have medical expense coverage.

Premiums paid out by the public for health and accident insurance now involve more money than for any other form of insurance except life insurance. It is evident that a revolution has taken place in medical economics.

Because the growth of voluntary insurance continues, it may be assumed that the third party will become an even more important factor in certain aspects of medical practice. No one can doubt that the third party in medicine is here to stay.

What new responsibilities—or re-shaping of old responsibilities—will this place on the members of the medical profession as individuals and as a group? The question deserves careful thought.

Does the new situation place any responsibility on the medical profession to protect the public against unsound insurance plans? Every active practitioner is aware that many thousands of dollars are spent by the public for health insurance that does not insure against the real hazards of illness.

Physicians realize that patients are continually seeking advice from them as to what type of insurance they should buy. Where, in this field, does the responsibility of medicine begin and where does it end?

It is conceded that it would be unwise for the medical profession to try and take over the health and accident insurance field. On the other hand, the profession has a stake both on behalf of itself and its patients to help protect the public from the occasional trick health insurance policy. The problem, of course, is one that intensely concerns the legitimate ethical health insurance underwriters.

Certainly, the medical profession is vitally concerned in this field of medical economics. The individual physician must realize his individual responsibility to assist in the promotion of a wholesome and solid voluntary health insurance program. Because it can be done effectively no where else, the individual physician has a major obligation to do what he can to prevent abuses of health insurance.

Whether it be non-profit insurance such as our own Blue Shield and Blue Cross, or one of the many commercial plans, it is important that premiums be kept as low as possible and that satisfaction on the part of the policy-holder be kept as high as possible. In both cases premiums will rise if unwarranted use of the insurance is permitted.

Health insurance is intended to provide a cushion for the costs of serious illness. It is not intended to pay for every minor expense. Whenever the patient spends an extra day in the hospital or receives treatment that is uncalled for, the cost of his insurance goes up. Figures have been compiled to show that this additional cost can be quite high. If it raises the premiums high enough, it will force the patient to drop his coverage. If they are to safeguard the American way, physicians must take the lead in explaining these facts of life to those who would soak themselves and their fellow policy holders by "soaking the company."

An equally serious responsibility of the individual physician is in keeping the patient satisfied with what his insurance provides him. A small number of cases have been reported in which physicians have charged higher fees to the patient who has insurance than they would if he had been uninsured. Whatever may be the reasons for this, it raises a serious question in the mind of the patient as to the value of his insurance. If we believe in voluntary health insurance, we should not penalize

those patients who are protected by it. When we succumb to the universal temptation to "soak the company," we are hurting ourselves both directly and indirectly.

Fortunately, abuses participated in or condoned by physicians have been relatively small in number. Any abuses, however, are too many. They hold the seeds of destruction for this uniquely American institution of voluntary health insurance. Every physician should recognize that times are changing and that his obligations are constantly taking new form. No where is this more true than in the field of medical economics.

WHY KSMA INTEREST IN LEGISLATION?

The Legislature of Kentucky is again in session.

If past experience is any indication, the two legislative bodies of the Commonwealth may be expected to do a good job of law-making for the people. The majority of their members have had a sincere desire to do what is best for Kentucky and their records are testimony to them.

Legislators, endeavoring to represent the will of the people, deeply appreciate the support of the solid elements in the community in the development of legislative acts. They are, in each session, confronted with a myriad of bills on which they must make a decision.

Some of these are obviously foolish, others are not so obvious, but equally dangerous. Legislators welcome the help of such groups as your Kentucky State Medical Association Legislative Committee and the opinion of community leaders from among their own constituency in informing themselves on all issues.

It is not known at this writing what this session will bring. It is evident, however, that bills will be introduced which are related to medicine and health. Bills in which every physician who has a regard for his patients' welfare will be interested. Some of these proposals will be good. Others will be harmful in the extreme.

It is legitimate and proper that your Association should concern itself with such matters. The Legislative Committee will do its best to give accurate information to the legislators and in turn report to KSMA members. This will be important work in keeping with the Association's objectives of good legislation for the people's benefit.

There may be occasions, however, when the most important work will have to be done by you. Most legislators feel that they have an obligation to represent their own constituents. Among those constituents, you are important. Should circumstances arise that the best interests of Kentucky are threatened by questionable bills, you will have the responsibility to your fellow citizens to make known to your legislator the pertinent information and sentiments which you have.

Your Legislative Committee will be on the job at Frankfort, but each of us will need to keep ourselves constantly informed as to what is going on and keep our own legislator informed as to feeling among the people he is trying to represent.

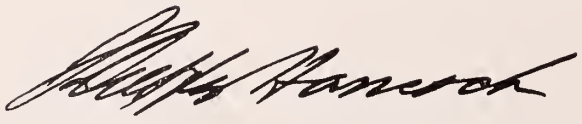
President's Page

As the old year departs, the universal greeting is "Happy New Year." Such I wish for all of you. Your other officers and the members of the headquarters staff join with me in hoping that 1954 will bring to you a realization of all your desires and resolutions.

Happiness is not all fun. It includes among other things the satisfaction of fulfillment of obligations. One of our first is the prompt payment of our Kentucky State Medical Association dues. Nowhere will we get so much for so little.

The ten dollar increase voted for this year should not be a burden. It is slightly less than the equivalent of a three cent postage stamp a day. It is the minimum amount needed to maintain our necessary activities and at the same time to remain solvent. All of us are critical of deficit spending by governmental agencies and do not want to follow that course in our own program.

If everyone pays his annual dues promptly, it will make the duties of your county medical society secretary much easier and it will add to the efficiency of your headquarters office.



PRESIDENT

ORGANIZATION SECTION

Dr. Greenwell Named "General Practitioner of the Year" By 1953 American Medical Association House of Delegates

First Kentucky Winner Receives Award At 7th AMA Clinical Session St. Louis, December 1-4

Selection Made by Secret Committee; Each State Submitted Nomination

For the first time in KSMA history, a Kentucky physician, Joseph I. Greenwell, M.D., of New Haven, was awarded the coveted title of "General Practitioner of the Year" by the American Medical Association, and presented with a gold medal and citation of service to his community, at the opening session of the House of Delegates during the AMA Annual Clinical Session in St. Louis, Missouri, December 1-4, 1953.

Dwight H. Murray, M.D., Napa, California, chairman of the AMA Board of Trustees, announced the identity of the physician to receive the seventh annual GP Award, after the selection had been made by a secret three man committee of the AMA Board. Each state medical association presented an outstanding general practitioner in nomination for the esteemed award.

J. Duffy Hancock, M.D., Louisville, president of the KSMA, said "The Kentucky State Medical Association has furnished the AMA with more presidents than any other state association. Now, we are extremely proud that Dr. Greenwell has become the first Kentucky physician to win the AMA'S Outstanding General Practitioner Award."

Dr. Greenwell received many congratulatory messages, one of which was from Lawrence W. Wetherby, governor of Kentucky, who telegraphed, "No heart in Kentucky glows brighter than mine in behalf of your achievement."

Also, the 1953 winner of the KSMA General Practitioner Award in September, Dr. Greenwell has devotedly served the people in his home county, Nelson, and the adjacent counties of Hardin, Marion and La Rue for the past 53 years.

Perhaps the greatest source of professional pride for the 80 year old Nelson county physician has been his babies. Dr. Greenwell estimates he has delivered over 4300, including one set of triplets. Of these, over 80 have been born in 1953, and no immediate retirement is contemplated by this tireless practicing physician.



Joseph I. Greenwell, M.D., New Haven, left, receives the 1953 AMA "Outstanding General Practitioner of the Year Award" from Edward J. McCormick, M.D., Toledo, AMA president, during the opening session of the House of Delegates, December 1, 1953, at the St. Louis Clinical Session.

Second only to the immediate welfare of his own patients, Dr. Greenwell's greatest interest has been furtherance of the medical profession. He has been active as a leader of organized medicine in Kentucky on the state, district and county level. This year, Dr. Greenwell completed 30 years of service as a councilor to the Kentucky State Medical Association. No other man in the association's history has continuously represented his councilor district for such a long unbroken period.

A scrapbook, assembled by the KSMA Headquarters Office, was the medium for presenting the association's award winner to the AMA. Giving valuable technical assistance in preparing the scrapbook were employees of the printing firm of which Gradie Rowntree, M.D., Louisville, is the medical director. Ar-

rangements were made by Dr. Rowntree.

The scrapbook was handsomely bound in maroon morocco leather and contained full biographical material, photographs, clippings and other important information covering the long and useful life of the "Family Doctor of the Year."

On becoming a personality of national importance, Dr. Greenwell was much sought after by television, radio, the press and newsreels while attending the 1953 AMA winter meeting. After his return from St. Louis, Dr. Greenwell appeared on all three television stations in Louisville, on one half hour, and two quarter hour programs.

In addition, various newspapers and magazines have published articles on Dr. Greenwell's life, and many more have contacted the Headquarters Office for illustrations and material on the KSMA's and the AMA's choice of Outstanding General Practitioner for the Year 1953.

Ky. Rural Health Conference to Meet March 10-11, 1954

The 1954 Kentucky Rural Health Conference sponsored by the Kentucky Rural Health Council and the KSMA Rural Health Committee, will be held at the Kentucky Hotel, Louisville, March 10 and 11, according to a joint announcement by Walter L. O'Nan, M.D., Henderson, and Wyatt Norvell, M. D., New Castle, respective chairmen of the two groups.

The annual conference is a major project of the Rural Health Council and the KSMA Rural Health Committee in their efforts to stimulate and encourage lay leaders at the local level in rural Kentucky to voluntarily cooperate for better health.

The 1954 conference will begin in the Kentucky Hotel's Mirror Room at 1:00 p.m., Wednesday, March 10. There will be a dinner and evening session, Wednesday, and the conference will adjourn at noon, Thursday, March 11.

Nationally prominent speakers will participate in all three sessions of the conference. Other highlights of the meeting will include reports from individual Kentucky counties in which the people, working through rural health councils, have through their own voluntary cooperative efforts elevated the health standards of their own communities.

Dr. Norvell and Dr. O'Nan are both urging all KSMA physicians and members of the Woman's Auxiliary to lend support to the rural health council movement by urging laymen in their own communities to attend the conference. Since the movement involves no effort to impose rural health councils from above, they both have emphasized that it is important that as many rural lay leaders attend the conference as possible, especially farmers, farm wives and those who work with farm people.

KSMA Physicians Attend 7th AMA Clinical Session, St. Louis

Thirty-four physicians from Kentucky were among the approximately 3500 members of the medical profession who attended the seventh Annual Clinical Session of the American Medical Association in St. Louis, Missouri, December 1-4, 1953, announced George F. Lull, M.D., Chicago, secretary and general manager of the AMA.

Clark Bailey, M.D., Harlan, and Bruce Underwood, M.D., Louisville, were Kentucky Delegates to the winter meeting.

John B. Floyd, M.D., and Franklin B. Moosnick, M.D., both of Lexington, presented a scientific exhibit, "Pancreatitis: Treatment Based Upon Pathogenesis," which consisted of panels covering basic anatomy and physiology of the pancreas and pancreatic secretion with particular emphasis on disturbances in physiology which occur.

Physicians from Kentucky who registered at the Clinical Session, according to the Daily Bulletin issued by the AMA from St. Louis, include:

December 1, 1953

William V. Eaton, M.D., Paducah; Harold F. Funke, M.D., Bardwell; Franklin B. Moosnick, M.D., Lexington.

December 2 1953

Joseph A. Ballard, M.D., Lexington; Charles Baron, M.D., Covington; Eugene Blake, M.D., Paducah; Leslie W. Blakey, M.D., Cadiz; Warren W. Borsch, M.D., Louisville; Robert Logan Chase, M.D., Glasgow;

John E. Dunn, M.D., Paducah; Alfred Glattauer, M.D., Brandenburg; Guthrie Y. Graves, M.D., Bowling Green; Michael M. Hall, M.D., Campbellsville; Kenneth L. Lockwood, M.D., Outwood;

Thomas J. Marshall, M.D., Paducah; Ernest E. Ramey, M.D., Wickliffe; Melvin J. Weber, M.D., Ludlow; Charles A. Wood, M.D., Auburn; Thomas J. Wright, M.D., Stanford;

December 3, 1953 (morning)

Marion F. Beard, M.D., Louisville; Nathan Canter, M.D., Owensboro; James B. Douglas, M.D., Louisville; Wilbur R. Houston, M.D., Erlanger; David Y. Keith, Jr., M.D., Paducah;

Felix A. Olash, M.D., Louisville; Robert R.

Rudd, M.D., Fulton; Alex J. Steigman, M.D., Louisville; Joseph A. Stoeckinger, M.D., Lexington; Fred B. Weller, M.D., Pineville;

December 3, 1953 (afternoon)

Asa Barnes, M.D., Louisville; Joseph I. Greenwell, M.D., New Haven; Joshua B. Lukins, M.D., Louisville; Guy Morford, M.D., Owensboro; Edwin Bruce Underwood, M. D., Louisville.

Committee Plans Program For 14th Industrial Health Congress

The KSMA Committee on Industrial Medicine and Surgery met November 3, Louisville, with Carl M. Peterson, M.D., secretary of the Council on Industrial Health of the AMA, and with other representatives in allied fields to discuss plans for the Fourteenth Congress on Industrial Health to be held February 23-25, 1954, at the Brown Hotel, Louisville, according to Gradie R. Rowntree, M.D., Louisville, chairman of the Committee on Arrangements.

Topics selected by the committee to be discussed include: emergency service in industrial plants, bringing health and safety to small plants, types of disasters and community defense organizations, among others.

It was stated there would be approximately three hundred out-of-town guests who would attend the Industrial Health Congress. Other scheduled program events are: keynote speakers from labor, management or government, the president's award and a program on rehabilitation.

AMA House of Delegates Takes Action on Medical Issues

At the Seventh Annual Clinical Session the House of Delegates of the American Medical Association took actions on such issues as social security, voluntary health insurance, hospital accreditation, medical ethics and unethical practices along with a number of other matters of interest to both the public and the medical profession.

It approved a recommendation of the Reference Committee on Legislation and Public Relations of which Bruce Underwood, M.D., Louisville, K.S.M.A. Delegate, was chairman, reaffirming its opposition to the compulsory coverage of physicians under the Old Age and Survivors Insurance provisions of the Social Security Act. It passed another recommendation of that Committee advocating congressional adoption of the Jenkins-Keogh bills which are now pending in Congress.

The Reference Committee report said: "The purpose of these bills is to eliminate the discrimination, and inequities which exist under present tax laws by extending the tax deferment privilege to the country's ten million self-employed...."

Continued support of the Bricker Amendment (S.J. Res. 1) and the approval of principles of legislation which would reduce or remove the limitation on the deduction of medical and dental expenses for income tax purposes was urged by the Committee report. It asked for the discontinuing of the "Doctor Draft" Law after its expiration, June 30, 1955.

Another action by the House dealing with voluntary health insurance stated, "the American Medical Association condemns all insurance contracts which classify any medical service as a hospital service." The resolution reaffirms previous actions of the House defining pathology, radiology and anesthesiology as medical services.

On the subject of the Joint Commission on Accreditation of Hospitals dealing especially with the role of the Department of General Practice in a hospital, the House of Delegates said:

"That this House of Delegates of the American Medical Association request the Joint Commission on Accreditation of Hospitals to publish an article, or series of articles, in the Journal of the American Medical Association and other official publications circulating among the medical and hospital professions, to acquaint the medica-hospital profession with the regulations, bylaws and their interpretations, and

"That the Commission clarify the methods by which an aggrieved hospital or its staff may appeal a decision with which they are not in agreement."

Lexington Site of 4th Officers Conference, April 15

Lexington's Phoenix Hotel will be the site of the Fourth Annual County Society Officers Conference, Thursday, April 15, 1954.

Features of the program were selected by county officers, who completed questionnaires, following the conference last year. The local officials selected subjects they felt to be of the most interest of them and their problems.

Nationally prominent experts in the various fields will present the subject matter your of-

ficers selected last year. In addition a panel is being arranged to deal with the subject most chosen—"Building and Strengthening the Activities of the County Medical Society."

The conference is sponsored by the Council of the Association. Its purpose is to present practical information and techniques in local medical society organization activities, which will enable KSMA members to be more effective in this field of service.

County Medical Society Officials and committee chairmen are warmly invited to the conference by the KSMA officers and Council. All KSMA members are welcomed.

VA to Seek Financial Information in Non-Service Cases

In the future the Veterans Administration will require additional financial information from veterans who apply for hospitalization of non-service connected conditions reports the AMA Washington office.

Previously, veterans applying for such hospitalization were asked only whether they were financially able to pay the necessary expenses. If the veteran answered "no," he was considered eligible and was asked no more questions. Now, he will be required to provide additional information about his finances on a special form, referred to by the Veterans Administration as "addendum to form P-10."

The AMA Washington Letter points out in a recent issue that physicians should keep in mind that this amendment is a step in the right direction, but falls short of meeting the AMA recommendation that: (1) non-service care be restricted to tuberculosis, mental and neurological cases where the veteran cannot afford care; (2) all other non-service cases be made the responsibility of the veteran himself or the community.

'Diabetes Drive Again Successful' Report County Societies

Early reports from the county medical societies indicate that the 1953 Diabetes Detection Drive sponsored by the Kentucky State Medical Association, November 15-21, has again been successful in its efforts to save lives through discovery of Kentucky's unknown diabetics, according to Carlisle Morse, M.D., Louisville, chairman of the KSMA Diabetes Committee.

"A number of counties have not yet reported on the results of their county's drive," Dr. Morse continued, "but, they are coming in very well from most chairmen.

"Many chairmen have made the comment that there has been a greater interest on the part of both the public and the physicians in this year's campaign than ever before," he continued. Recognizing the importance to effective future publicity for the annual drive, a number of chairmen have also reported the names of physicians who care for persons newly discovered as diabetics through the drive.

"The KSMA Diabetes Committee deeply appreciates the splendid cooperation received from the county medical society diabetes committees in organizing the drive in their own communities. The greatest contribution has, of course, been made by the profession at large through their willingness to give the free urine sugar tests to all persons requesting them during the National Diabetes Week.

"Cooperation from groups and individuals outside of the medical profession has also been instrumental in making the campaign a success," Dr. Morse said.

"The Kentucky wing of the Civil Air Patrol cooperated by operating an airlift for testing materials; members of the Kentucky Pharmaceutical Association assisted by serving as specimen collecting agencies in many communities; the Kentucky State Dental Association displayed posters throughout the state; numerous other groups endorsed the drive and publicized it to their members, and the help provided by newspapers, radio stations and television stations was outstanding."

Auxiliary Buys Station Wagon For Cancer Society

The statewide drive to raise funds for a new station wagon for the Kentucky Cancer Society, sponsored by the Woman's Auxiliary to the KSMA, exceeded its goal of $1200 by $68, with additional contributions still being received, announced Mrs. Malcolm Barnes, Louisville, chairman of the cancer fund raising committee.

Mrs. Clyde C. Sparks, Ashland, president, thanked the presidents of the county auxiliaries for their conscientious participation in the successful campaign at a KSMA Auxiliary Board Meeting, Brown Hotel, Louisville, December 3, 1953.

In her report, Mrs. Barnes indicated that a number of the contributions from the smaller counties reached one hundred per cent and above in some instances. The funds collected

were used to purchase a station wagon which was decorated and presented as a Christmas gift to the Kentucky Chapter of the American Cancer Society on December 17. The presentation was held in front of the headquarters office of the Kentucky State Medical Association.

Dr. Hancock Addresses Meeting of Eleventh Councilor District

J. Duffy Hancock, M.D., Louisville, president of the Kentucky State Medical Association, spoke on "Opportunities for Service" at the annual dinner meeting of the KSMA Eleventh Councilor District, held November 18, at the Benault Inn, Richmond, according to Hugh Mahaffey, M.D., eleventh district councilor and presiding officer.

"Chest Pains" was the topic of J. Murray Kinsman, M.D., Louisville, dean of the University of Louisville School of Medicine who was also a featured speaker at the meeting. William C. Cloyd, Jr., M.D., president, Madison County Medical Society, officially welcomed approximately 70 attending physicians and their wives.

Mrs. Garland Clark, Winchester, eleventh district councilor for the Woman's Auxiliary to the KSMA brought greetings from the auxiliary and commented on her organization's effort to help the cancer program. In addition to the physicians from Louisville, guests were present from Lexington and Pikeville.

County Society PR Courses Draw 150 Physicians' Assistants

Approximately 150 physicians' assistants have completed participation in the office personnel public relations course presented by the Fayette County Medical Society and the Campbell-Kenton County Medical Society with the cooperation of the KSMA Education Campaign Committee, it has been reported by W. Vinson Pierce, M.D., Covington, chairman of the KSMA Committee.

The course presented under Fayette County Medical Society sponsorship in Lexington, October 13, November 3 and November 24, was attended by more than 100 girls. The Campbell-Kenton County Society presented the course in Covington, October 26, November 9 and November 23, with an average attendance of approximately 50.

According to Dr. Pierce, the course is available for all county medical societies throughout Kentucky. Arrangements can be made through the Kentucky State Medical Association's Headquarters Office, 620 South Third Street, Louisville, Kentucky. Several counties are planning to offer the public relations course this spring.

Certificates of recognition were presented to each member of a physician's staff who had completed the course of instruction. At Lexington this was done by John B. Floyd, Jr., M.D., secretary of the Fayette County Medical Society. In Covington the presentation was made by W. Vinson Pierce, M.D., at the request of Arthur M. Schultz, M.D., Campbell-Kenton County Medical Society president.

Both societies extended an invitation for physicians in adjoining counties to send their office personnel. In consequence, approximately eight counties were represented in the two courses.

SMA Attracts 62 Ky. M.D.'s to Atlanta, October 26-29

Sixty-two Kentucky physicians were among the 2,347 who attended the 1953 Southern Medical Association Annual Meeting in Atlanta, October 26-29, it was reported by C. P. Loranz, secretary and general manager.

Physicians from Kentucky who attended the SMA Annual Meeting include:

Albert Lanham Allen, M.D., Ashland; K. R. Andrews, M.D., Lexington; John C. Baker, M.D., Berea; Carey C. Barrett, M.D., Lexington; D. W. Barrow, M.D., Lexington; Eli C. Boggs, M.D., Hazard; M. E. Brackett, M.D., U. S. Army; Marion G. Brown, M.D., Lexington; B. Earl Caywood, M.D., Danville; S. C. Clarkson, M.D., Lebanon;

Clarence T. Coleman, M.D., Frankfort; James R. Dade, M.D., Hopkinsville; Frank L. Duncan, M.D., Monticello; Jacob Duncan Farris, M.D., Lexington; Ralph L. Gullett, M.D., West Liberty; M. M. Hall, M.D., Campbellsville; C. H. Heisel, M.D., Covington; Vester A. Jackson, M.D., Clinton; R. F. Jasper, M.D., Somerset; David L. Jones, M.D., Fulton;

Jack C. Keeley, M.D., Owensboro; Millard C. Loy, M.D., Columbia; William K. Massie, M.D., Lexington; Lloyd D. Mayer, M.D., Lexington; A. O. Miller, M.D., Scottsville; D. G. Miller, Jr., M.D., Morgantown; Ray E. Murphy, Jr., M.D., Lexington; Willis Payne McKee, M.D., Eminence; Samuel M. Rickman, M.D., Paris; Joseph N. Rose, M.D., Williamsburg;

J. A. Ryan, M.D., Covington; Raymond D. Sanders, M.D., Williamsburg; A. J. Schwertman, M.D., Covington; John W. Scott, M.D.,

Lexington; M. L. Smith, M.D., Maceo; L. O. Toomey, M.D., Bowling Green; W. L. Tyler, M.D., Owensboro; Ben T. White, M.D., Cadiz.

Louisville physicians:

Irvin Abell, Jr., M.D., S. Pearson Auerbach, M.D.; J. C. Bell, M.D.; Glenn W. Bryant, M.D.; M. R. Cronen, M.D.; Paul E. Doerman, M.D.; Robert S. Dyer, M.D.; W. M. Ewing, M.D.; John S. Harter, M.D.; W. O. Johnson, M.D.; Robert Lich, M.D.; Jesshill Love, M.D.;

Lanier Lukins, M.D.; Paul Mapother, M. D.; Robert F. Monroe, M.D.; William Ray Moore, M.D.; Carlisle Morse, M.D.; Arthur Clayton McCarty, M.D.; H. N. Ritter, M.D.; Ephraim Roseman, M.D.; Winston V. Rutledge, M.D.; James E. Ryan, M.D.; S. P. Suerbach, M.D.; and Karl D. Winter, M.D.

Ky. Physicians Pledge $43,000 to John Walker Moore Fund

by Sam A. Overstreet, M.D., Louisville, Chairman

During the past year there have been 403 physicians who have subscribed $43,000 to the Dr. John Walker Moore Professorship Fund and $22,553 has been paid. This rather widespread response among the students and friends of Dr. Moore has been encouraging.

The solicitation will continue—not for this year only, but for five years or as long as there are those who continue to wish to contribute to this worthy and urgently needed fund. Some have sent cash donations and have indicated that they will pay or subscribe further.

Others have made subscriptions indicating that as favorable conditions continue they will enlarge and extend these payments over a longer period of time. Many have felt that they were not in a position to subscribe at all or in the amount they desired to give, but will do so at a future date.

Other members of the fund raising committee are: S. Spafford Ackerly, M.D., Louisville, and J. Murray Kinsman, M.D., Louisville.

Garrard County First to Report

Garrard County Medical Society is the first society in the state to send in its complete list of county officers, committee personnel and 1954 KSMA and AMA membership dues to the KSMA headquarters office in Louisville. The Garrard county material reached Louisville December 9, 1953.

Muldraugh Hill Society Hears Six Medical Discussions

The Muldraugh Hill Medical Society met December 10, 1953, at St. Anthony's Hospital, Louisville, it was reported by Joseph C. Ray, M.D., Louisville, secretary. The program was divided into morning and afternoon sessions and included six medical discussions.

Participating in the program was George F. Dyer, M.D., Louisville, who spoke on "The Responsibility of the Coroner to the Physician," along with Captain James Darragh, M.C., who discussed "Current Use of ACTH and Cortisone," and Louis S. Block, D.D.S., Louisville, whose topic was "Focal Infections."

Appearing as speakers on the afternoon program were Jean Clos, Jr., executive secretary of the Jefferson County Medical Society, who discussed "The Big Lie," Colonel Robert W. Boal, M.C., whose topic was "Low Back Pain," and Captain Lee Cattell, M.C., who spoke on "Observation and Management of Survivors of Major Air Plane Crashes." In addition, Judge Lee Roy Curtis, Sr., Louisville, enlightened the society and guests on "Medical Legal Problems."

Dr. Underwood to Serve on SJAB Advisory Committee

Bruce Underwood, M.D., secretary and general manager and editor of the Journal of the Kentucky State Medical Association, was recently appointed to serve on the Advisory Committee to the State Journal Advertising Bureau, it was announced at the AMA Medical Editors Convention, Chicago, November 9-10.

Dr. Underwood succeeds Walter Vest, M.D., Huntington, West Virginia, editor of the Journal of the West Virginia State Medical Association, who was one of the original members of the advisory committee.

Stanley Weld, M.D., editor of the Journal of the Connecticut State Medical Association and chairman of the Advisory Committee to the SJAB, announced the appointment of Dr. Underwood after highly praising the contributions Dr. Vest had made and thanking him for his many years of service.

The State Journal Advertising Bureau paid the expenses of two representatives from each of their state journals to the Medical Editors Conference. Two members of the staff of the Journal of the Kentucky State Medical Association attended.

Doctors Griswold and Fischer to Appear on ACS Panel

R. Arnold Griswold, M.D., Louisville, will preside over an afternoon panel discussion on "Nutrition and Pre- and Postoperative Care in the Aged," at the Fourth Sectional Meeting of the American College of Surgeons, to be held at French Lick Springs, Indiana, March 15-17, 1954.

K. Armand Fischer, M.D., Louisville, will participate in a panel discussion on "Indications for and Operative Methods in the Open Treatment of Fractures." In addition to a concentrated program of scientific significance, the program will be rounded out with medical motion pictures, said Carl H. McCaskey, M.D., chairman of the Committee on Arrangements, Indiana Chapter of the ACS.

Dr. Byrne Elected New President of Sixth Councilor District

Walter Byrne, M.D., Russellville, was elected the new president of the Sixth Councilor District at the last meeting November 10, 1953, at the Russellville Country Club, according to L. O. Toomey, M.D., councilor.

Other officers elected were Russell Starr, M.D., Glasgow, vice-president, and Richard F. Grise, M.D., Bowling Green, secretary. The Logan County Medical Society was host to approximately 40 physicians who attended the meeting.

The clinical program consisted of a presentation of "Management of Problems of Pelvic Pain" by Edward Williams, M.D., of the department of Obstetrics and Gynecology, Vanderbilt University Hospital, Nashville.

Surgical Group Includes 2 KSMA Physicians as Speakers

Two KSMA surgeons, John T. Bate, M.D., Louisville, and Franklin Jelsma, M.D., Louisville, will participate in the twenty-second Annual Assembly of the Southeastern Surgical Congress to be held at the Dinkler-Tutwiler Hotel, Birmingham, Alabama, March 8-11, 1954, according to J. Duffy Hancock, M.D., Louisville, president.

Dr. Bate will speak on "Repair of Inguinal Hernia in the Middle Aged Industrial Laborer," and Dr. Jelsma's topic will be "Some Complications of Head Injuries."

The last meeting in March, 1953, was held at the Brown Hotel, Louisville, and attracted approximately 500 physicians who heard 48 scientific discussions. Fifty-two papers will be presented at the 1954 assembly, of which 24 of these will be delivered by outstanding guest speakers from all over the nation. Also included in the scientific program will be four panel discussions.

Medical Color Television Seen at 7th AMA Clinical Session

A milestone in the history of medical color television was witnessed at the seventh Annual Clinical Session of the American Medical Association in St. Louis, December 1-4, 1953, when the television unit of Smith, Kline & French Laboratories presented its 50th program of colorcasting for the medical profession, according to the AMA.

The presentation covered a wide variety of diseases, including those of the brain, heart and blood vessels, eyes, gastrointestinal and reproductive organs, bone and muscle, and chest and throat. The demonstrations originated in the St. Louis City Hospital and were viewed at the meeting before screens on which pictures were enlarged 27 times greater than any previous projections.

Medical color television made its debut at the Annual Meeting of the AMA in Atlantic City in June, 1949. In December, 1951, the first transcontinental color transmission allowed physicians in New York and Chicago to witness the performance of a delicate heart operation in Los Angeles. The St. Louis program was the tenth in a series that have been presented before meetings of the AMA.

First Yandell Medal Awarded

The first annual David W. Yandell Medal was awarded by the Louisville Surgical Society to Emile Holman, M.D., professor of surgery at Stanford University School of Medicine, November 11, 1953. The award was instituted as a memoriam to Dr. Yandell, founder of the society, who was a professor of Surgery at the University of Louisville Medical School from 1869 to 1898.

The recipient of the award conducted several surgical conferences at the University of Louisville Medical School preceding his presentation of the annual Yandell award.

KSMA "Doctors Day" Is April 13

Tuesday, April 13, 1954, will be "Doctors Day" in Kentucky according to Mrs. Clyde C. Sparks, Ashland, president of the Woman's Auxiliary to K.S.M.A. Mrs. Sparks said there were no state-wide plans for the celebration of this day, but that each county auxiliary would plan its own program.

Ky. M.D. Heads AMA Committee

Bruce Underwood, M.D., Louisville, secretary and general manager of the KSMA, was designated by James R. Reuling, M.D., Bayside, New York, speaker of the AMA House of Delegates, to serve as chairman of the Reference Committee on Legislation and Public Relations at the American Medical Association Clinical Session, which met in St. Louis, December 1-4, 1953.

Symposium Held in Indianapolis

Carl Vernon Moore, M.D., dean elect of the Washington University Medical School, St. Louis, will be a featured speaker at a symposium sponsored by the Kentucky, Indiana and Ohio State Societies of Medical Technology at the Indiana University Medical Center, Indianapolis, January 22-23, 1954. KSMA members and medical technologists are warmly invited to attend, according to Katharine P. Muir, president of the Kentucky Society of Medical Technology. Doctor Bertha Osgood, of Indiana University, will also take part in the program.

Federal Scholarships Proposed

To interest medical students in military careers in the regular medical corps, the Department of Defense is planning to draft a legislative bill for federal scholarships in medicine. This plan is hoped to provide enough physicians to meet armed forces needs after expiration of the doctor draft in 1955.

Essential provisions of the plan: (1) any medical, dental, nursing, or veterinary student accepting a scholarship would be obligated for one year of federal service for each scholarship year; (2) payment would be made directly to the schools for tuition and other incidentals and to the student to cover living expenses during the school year; (3) scholarships, limited to four years, would not be offered to premedical students or others preparing for professional courses; (4) deans would make recommendations but final selection would be by the Defense Department.

Miami Society Conducts Poll

Display of the AMA plaque, "To All My Patients," an office display which encourages patients to discuss fees for medical services, was recommended as an excellent device for creating better relations with patients by the majority of 112 Miami, Florida, physicians who responded favorably to an informal poll conducted by the Dade County Medical Society, reports the AMA.

The poll revealed that discussion of fees was indicated to be "easy" by 42 per cent of the group, "relatively easy" by 35 per cent, "fairly difficult" by 15 per cent and "difficult" by only 8 per cent. The AMA is continuing to offer this plaque for one dollar to help practicing physicians create better relations with their patients. For complete information, contact your KSMA Headquarters office.

Dr. Harter to Head Chest Group

John Harter, M. D., Louisville, was elected president of the Southern Chapter of the American College of Chest Physicians during the Southern Medical Association Meeting in Atlanta, Georgia, October 26-29. The college, which includes 16 states and Washington, D.C., has a membership of approximately 200. Joseph S. Cruise, M.D., Atlanta, Georgia, was elected secretary-treasurer.

New Members Welcomed

The Kentucky State Medical Association recently welcomed two new members for the 1953 year. The new members are:

Morris M. Garrett, M.D., 630 Scott St., Covington.

Charles Justice, Jr., M.D., St. Elizabeth Hospital, Covington.

Pertinent Paragraphs

Beginning in January, 1953, the American Medical Association will drop all cigarette, tobacco, and alcoholic-beverage advertising from its publications, disclosed Tom Gardiner, AMA business manager. The decision was made after a readership study revealed that a sufficient number of members did not wish to see such advertising in the AMA publications. Beginning with the AMA Annual Meeting in San Francisco, June 21-25, 1954, there will be no more technical exhibits sponsored by cigarette companies.

Diabetes was the subject of a special, extensive symposium exhibit at the seventh Annual Clinical Session of the AMA, held in St. Louis, December 1-4, 1953, reports the AMA. The importance of the control of the disease in the prevention of serious complications was stressed and new data was submitted on the management of pregnancy in diabetic patients, and diabetic coma and its treatment.

Twenty-seven million people are now enrolled in Blue Shield medical care plans, according to a recent announcement by the Blue Shield Commission in Chicago, national headquarters of the non-profit, physician sponsored organizations.

A nationwide study to determine the effectiveness of a vaccine in preventing poliomyelitis will begin in one or more southern states during the week of February 8, 1954, announced the National Foundation for Infantile Paralysis. This study marks the beginning of a mass vaccination project which will include more than two hundred counties throughout the United States, in a gradually expanding program which will climax in June. Final results of the evaluation study are not expected until some time in 1955.

In an effort to control unfounded medical claims, the National Association of Radio and Television Broadcasters is enforcing the Code of the NARTB, which has been adopted by all of the major broadcasters in the United States, it was disclosed by the AMA. The Code specifically refers to medicine in sections dealing with "Advertising of Medical Products," and "Dramatized Appeals and Advertising." A close liaison has been set up by the AMA Public Relations Department with the NARTB in an effort to continually improve the quality of medical advertising and to immediately check any infringement of the Code's rules.

The Council on Postgraduate Medical Education of the American College of Chest Physicians will sponsor the second Regional Postgraduate Course on Diseases of the Chest in New Orleans, February 15-19, 1954, and the seventh Annual Postgraduate Course on Diseases of the Chest to be held at the Bellevue-Stratford Hotel, Philadelphia, March 15-19, 1954. Further information may be secured from your KSMA Headquarters Office.

A recent issue of "America," the Jesuit magazine, carried an editorial upholding the American Medical Association's opposition to government medical care for veterans with non-service-connected disabilities. The article cited in part that more than $500 million was spent on veterans' medical care in 1952, of which only $178 million went for care of service-connected disabilities.

Edward J. McCormick, M.D., Toledo, Ohio, president of the American Medical Association, was recently presented with a resplendent head-dress of eagle feathers and a new title, Doy-Om-Keah Kah-Ti-Kei, of Indian origin, by the Kiowa Tribe of Indians at a ceremony arranged by the Oklahoma City Chamber of Commerce and the Oklahoma City Clinical Society.

Demand for AMA radio transcriptions on common health subjects hit an all-time high during 1953 with more than 700 sets distributed for broadcasting over local radio stations in all parts of the country, reports the AMA Bureau of Health Education. Thirteen state medical societies help the AMA in distributing the transcriptions, which are provided without charge as a public service.

A three dimensional X-ray motion picture was shown for the first time in the mid west during the seventh Annual Clinical Session of the American Medical Association, December 1-4, according to the AMA. The 3-D film provided a stereoscopic X-ray view of talking and swallowing, and the passage of barium through the chest portion of the esophagus.

"Your Doctor," a new type of magazine designed and written especially for patients to read while waiting to see their physician, is currently appearing free of charge to every member of the Oklahoma State Medical Association. A unique characteristic of "Your Doctor" is the size, a square 11¼ inches, which cannot be covered up in a stack of magazines. Paul Andres Publications created the novel magazine for public relations purposes, and hopes to begin regional issues within the next 12 months.

Approximately 3,825 persons are actively engaged in medical social work in the U. S. today, according to the Public Health Service of the Department of Health, Education and Welfare. However, three times as many positions are open in this field as there are persons to fill them. A source book on the subject containing data on employment, educational background, and personal characteristics of medical social workers can be obtained through your KSMA headquarters office.

The Fifth Annual International Group of Physicians in Alcoholic Anonymous will meet at the Mayflower Hotel, Akron, Ohio, May 14, 15, and 16, 1954, according to H. D. Chamberlain, M.D., chairman of the meeting. Last year physicians were present from as far south as Florida and as far west as Colorado.

James Somerville McLester, M.D., Birmingham, Alabama, was the recipient of the Joseph Goldberger Award from the AMA through its Council on Foods and Nutrition at a meeting in St. Louis of the Board of Trustees of the AMA. Dr. McLester, regarded as the dean of American medical nutritionists, was singled out for the citation because of the outstanding role he has played in translating the results of nutrition research into human values for the American people, states the AMA.

Representatives from forty nations will attend the Third International Congress of Internal Medicine to be held in Stockholm, Sweden, September 15-18, 1954, under the auspices of the International Society of Internal Medicine. The program will include two symposiums, among other features, one dealing with hypertension, and the other with collagen diseases.

Eight fellowships in industrial medicine are being offered by the U. S. Atomic Energy Commission during 1954 and 1955. Following successful completion of one year's academic training at institutions offering approved graduate courses in industrial medicine, a candidate becomes eligible for a second year of in-plant training given in medical departments of major AEC plants and laboratories. Details on applying for a fellowship can be obtained from the KSMA Headquarters Office.

Life Magazine in the November 23rd issue carried an informative article on the Montefiore Hospital Headache Clinic in New York, which was established eight years ago to specialize in the treatment of headache, a widespread malady in the United States from which approximately 12 million Americans suffer annually. Last year, Montefiore, aided by a variety of intricate devices for calculating eyestrains, brain impulses and the flow of blood treated 17,000 patients.

"School Health in Action," is the subject of a new sound and color film which has recently been added to the AMA motion picture library. The film was produced for the Oklahoma State Department of Health with the cooperation of the Oklahoma State Medical Association. The service charge is two dollars; requests should be made to the AMA's Committee on Medical Motion Pictures.

In the November issue of the L & N Railroad's trade publication, a picture appeared of a group of outstanding KSMA personalities who were guests at the annual L & N luncheon honoring local and district surgeons. Approximately 75 hosts and guests were present at the affair which occurred September 22, 1953, during the Annual Meeting of the KSMA.

A new type of medical publication designed for busy physicians is "Audio Digest," which consists of condensed articles which are selected from 1,900 publications issued on sound recording tape. Narrated in terse, listenable form, "Audio Digest" deals with ideology, diagnosis and treatment and may be listened to on a tape recorder at the office, at home, or while driving a car. Additional information may be obtained by writing "Audio Digest," 404 East Broadway, Glendale 5, California.

News Items

Eldon Raymon Dykes, M.D., in July became associated in practice with **Charles Aker, M.D.,** Lackey, in Floyd county. A graduate of the University of Tennessee College of Medicine, Memphis, in 1952, Dr. Dykes interned at Philadelphia General Hospital, Philadelphia, Pennsylvania.

Millard R. Shaw, M.D., formerly of Tripp, South Dakota, recently opened an office in Henderson for the practice of internal medicine. A graduate of the University of Utah School of Medicine in 1944, Dr. Shaw interned at City Hospital in Akron, Ohio, and completed a three year residency in internal medicine in 1950 at the Veterans Administration Hospital, Louisville.

Irvin Zeavin, M.D., Lynch, recently prepared a report with three Colorado physicians on the effectiveness of lowering the body temperature in direct vision heart surgery, which was published in the November 21st issue of the Journal of the American Medical Association, according to George F. Lull, M.D., secretary and general manager of the AMA.

Robert S. Howell, M.D., formerly of Louisville, recently opened an office for general practice in Frankfort. Dr. Howell was graduated from the University of Louisville School of Medicine in 1952 and interned at St. Joseph's Infirmary, Louisville.

John P. Darling, M.D., recently joined the medical staff of the Methodist Hospital in Pikeville for the practice of pathology. Dr. Darling was graduated from Rush Medical College, Chicago, in 1936, and interned at Cincinnati General Hospital, Cincinnati, Ohio. He was formerly associated with Mayo Clinic, Rochester, New York.

Frederick F. Ferguson, M.D., formerly of Nashville, Arkansas, recently became associated with Trover Clinic in Madisonville, specializing in urology. Dr. Ferguson was graduated from the University of Arkansas School of Medicine, Little Rock, in 1944. He interned at the United States Naval Hospital, Memphis, Tennessee.

Naven M. Olson, M.D., formerly of Iowa City, Iowa, recently became associated with **German P. Dillon, M.D., Alfred T. Wagner, M. D.,** and **Fred M. Williams, M.D.,** all of Louisville, for the practice of anesthesiology. A graduate of the University of Iowa College of Medicine in 1947, Dr. Olson interned at the City of Detroit Receiving Hospital, Detroit, Michigan. He received additional training in anesthesiology at the Veterans Administration Hospital in Des Moines, Iowa, and the University of Iowa Hospital.

Roy Edwards, M.D., formerly of Cleveland, Ohio, was appointed the new Superintendent of Western State Hospital, Hopkinsville, during October. Dr. Edwards was graduated from the Medical College of Virginia, Richmond, Virginia, in 1948 and interned at the Virginia University Hospital.

William Faxon Payne, M.D., formerly of Nashville, Tennessee, recently opened an office in Hopkinsville for the practice of obstetrics and gynecology. Dr. Payne was graduated from the Vanderbilt University School of Medicine in 1948 and interned at Vanderbilt University Hospital.

Henry Carl Riegler, M.D., and **Vea J. Riegler, M.D.,** formerly of Buffalo, New York, have opened separate offices in Paducah for the practice of surgery and anesthesiology, respectively. The two physicians are graduates of the University of Arkansas School of Medicine, Little Rock, Arkansas. Dr. Henry Riegler was graduated in 1944, and his wife, Dr. Vea Riegler, was graduated in 1943. He interned at Santa Rosa Hospital, San Antonio, Texas, and she interned at the University of Arkansas Hospital of Medicine, in Little Rock, later receiving additional training in anesthesiology at the Buffalo General Hospital, Buffalo, New York.

Harry H. Hartleb, M.D., formerly of Drakesboro, returned to Kentucky from Mt. Carroll, Illinois, in December, to open an office in Pembroke. Dr. Hartleb was graduated from the University of Louisville School of Medicine in 1951.

DIGEST OF PROCEEDINGS

(Continued from Page 36)

row, attended the Annual Meeting of the American Medical Association's Auxiliary to New York, the Conference of Presidents and President-Elects in Chicago and various other county meetings

Apparently this organization has been very active and certainly it receives the support and its work is commended by Reference Committee No. 5.

Mr. Speaker, we move the adoption of the report as a whole.

Motion was seconded and carried that the report be adopted.

The committee now moves the adoption of this report as a whole.

Motion was seconded and carried the report be adopted.

Reference Committee No. 5

Charles B. Stacy, M.D., Pineville, Chairman
H. G. Wells, M.D., Georgetown, Vice-Chairman
John C. Quertermous, M.D., Murray
Carl Pigman, M.D., Whitesburg
John W. Scott, M.D., Lexington

There was no unfinished business to be considered at this time.

Theodore Adams, M.D., of Lexington, made a motion that the Council report be re-opened for discussion in order that the question of raising the dues might be considered further. He said many did not know what was being voted on and there seems to be an excess of income over expenses in the Audit. Motion was defeated.

At this time Dr. John Scott of Lexington discussed the doing away with the offices of Orator in Medicine and Orator in Surgery. He said it was an honor to receive this title and that all in the past had presented good, worthwhile papers. He said it was an office of dignity which men were honored to receive.

The Nominating Committee presented its candidates for the office for the coming year, and the following were elected:

President-Elect...Clyde C. Sparks, M.D., Ashland

Vice Presidents:

Central.....Robert O. Joplin, M.D., Louisville
Eastern.....Wyatt Norvell, M.D., New Castle
Western.....Leon Higdon, M.D., Paducah

Secretary (5yrs.).Bruce Underwood, M.D., Louisville

Treasurer (5 yrs.).....Woodford B. Troutman, M.D., Louisville

Speaker (3 yrs.)..Charles A. Vance, M.D., Lexington

Vice-Speaker (3 yrs.).E. W. Jackson, M.D., Paducah

Orator in Surgery..John E. Haynes, M.D., Madisonville

Orator in Medicine..Robert S. Dyer, M.D., Louisville

A.M.A. Delegate..Bruce Underwood, M.D., Louisville

Alternate A.M.A. Delegate...Coleman C. Johnston, M.D., Lexington

At this time nominations were made for the Board of Directors of Kentucky Physicians Mutual, Inc. The Board will choose five members from the names submitted. The names are as follows:

O. O. Miller, M.D., Louisville, J. Vernon Pace, M.D., Paducah, Walter L. O'Nan, M.D., Henderson, Kenneth Barnes, M.D., Princeton, William Cartmell, M.D., Maysville, and William Massie, M.D., Lexington.

The Nominating Committee for the 1954 Annual Meeting was elected as follows: Marion F. Beard, M.D., Louisville, Howell Davis, M.D., Owensboro, Carl Fortune, M.D., Lexington, John S. Harter, M.D., Louisville, and T. O. Meredith, M.D., Harrodsburg.

At this time the delegates from the counties in the districts which were to elect councilors held individual meetings. The following councilors were elected:

First District.....J. Vernon Pace, M.D., Paducah
Second District...Walter L. O'Nan, M.D., Henderson
Third District.....Delmas Clardy, M.D., Hopkinsville
Fourth District....W. Keith Crume, M.D., Bardstown
Seventh District...B. B. Baughman, M.D., Frankfort
Ninth Ditrict.....J. M. Stevenson, M.D., Brooksville
Eleventh District..Hugh Mahaffey, M.D., Richmond
Twelfth District.Garnett J. Sweeney, M.D,. Liberty
Thirteenth District....Charles B. Johnson, M.D., Russell
Fourteenth District..John Archer, M.D., Prestonsburg

There being no further business the meeting adjourned at 9:25 P. M.

Washington News Digest

Editor's note: "Washington News Digest" is making its bow in the Journal of the Kentucky State Medical Association. The material in this new monthly feature is prepared and distributed by experienced capitol observers in the AMA Washington office, Frank Wilson, M.D., director.

Washington, D. C.—The second session of the 83rd Congress is getting down to its task under conditions that could mean passage of considerable legislation of importance to medicine. Holding over from last session, or certain to be introduced this year, are bills touching on virtually every phase of medicine where the federal government could become involved. New laws are being proposed on veterans' care, social security, national health plans, care of military dependents, medical scholarships for military personnel, and many other subjects.

What will be done with this mass of legislation depends on an administration whose control over Congress is tenuous and a Congress looking forward to the fall, when all members of the House and one third of the Senate must be elected or reelected. As is the case every two years, most lawmakers will be listening closely to what's being said back home.

Awaiting congressional action is the administration's plan for extending the social security system to bring more than 10,000,000 additional persons, including physicians, under Old Age and Survivors Insurance (OASI). This legislation is known to have less support in the House Ways and Means Committee, where it is being handled, than it has in the Executive Branch.

American Medical Association, supported by dentists, lawyers, farmers, and many other groups of self-employed, has consistently opposed inclusion under OASI. The question now is whether this opposition will be articulate enough to convince Congress.

In place of social security for physicians, the AMA for several years has actively promoted legislation identified first as Reed-Keogh, then as Jenkins-Keogh, named for the sponsoring congressmen. This would allow physicians and other self-employed to defer income tax payments on a portion of their income, placed in restricted pension funds, obtainable in the form of benefits only in case of disability or at the specified retirement age. In this effort the physicians again are joined by a large group of associations representing the self-employed.

Other possible amendments to the social security law involve total and permanent disability payments and waiver of OASI premiums for the disabled, so their final pensions won't be reduced because of periods when they had little or no income. In each of these, medical determinations would be required. In the past, these bills have threatened an expansion of the federal medical program, have laid out an unreasonable role for the physician, or have called for compulsory rehabilitation. While not opposed to the objectives, AMA has urged that both the patient and the physician be protected. In place of waiver of premium, the AMA proposes that pension rates be based on the 10 best earning years, thus obviating the need for medical determinations.

As in other sessions, Congress this year probably will be asked to pass legislation providing free hospitalization under OASI for all persons past 65 covered by OASI, and for other beneficiaries of the program. In other years Congress has not taken this idea seriously.

The veterans program is certain to provoke action. Last November, Veterans Administration amended its forms to require more financial information from veterans applying for hospitalization of non-service connected disabilities, who must state that they cannot afford private care. Congress may want to further clarify the government's obligation to veterans. It is expected also that special effort will be made to expand medical benefits for veterans by such methods as increasing the periods in which certain diseases may be presumed to be of service origin.

AMA's position on the care of non-service connected cases is well known. It consists of three points. First, the best possible care by VA for actual service-connected cases. Second —until local and state facilities are adequate— VA care for long-term tuberculosis and neurological cases when the veteran himself can't pay. Third, all other non-service connected cases to be the responsibility of the veteran himself, his family, or his community.

The Defense Department has served notice that this session it will press hard for implementation of the Moulton Commission's recommendations for broadening the medical care program for military dependents. The Commission favored caring for as many dependents as possible at military installations, with the others receiving private care and the federal

(Continued on page 57)

County Society Reports

HOPKINS

The Hopkins County Medical Society met at the Hopkins County Hospital, Madisonville, October 30, 1953, with 16 physicians present. The meeting was called to order by the president, R. J. Dancey, M.D.

Lee Adams, county health administrator, and William E. Coffman, hearing consultant with the State Health Department, also attended the meeting to present to the physicians the Health Department's Hearing Conservation Program. Mr. Coffman explained the working of the plan, its benefits to the child, and its correlation with physicians in the county.

J. R. Corum, M.D., announced that test materials had been received for use in the Diabetic Detection Drive for the week of November 15. Carl F. Wieler, hospital administrator, reported that specimens could be brought into the hospital laboratory and the reports of the same would be forwarded to the patient's physician.

There was a general discussion of the measures under way to secure the services of a pathologist at the Hopkins County Hospital. Mr. Wieler discussed the shortage of beds at the hospital and asked that three physicians be appointed as a committee to assist in consultation on long-stay patients with the attending physician to determine if such a patient could be safely discharged, thus releasing a hospital bed for more critically ill patients.

Communications received from the AMA were presented to the society. After the business meeting, J. L. Salmon, M.D., F. S. Trover, M.D., and M. M. Mahr, M.D., of the Hopkins County Hospital medical staff, presented cases of recently hospitalized patients with early cirrhosis of the liver and obstructive jaundice.

Loman C. Trover, M.D., Secretary

McCRACKEN

The monthly dinner meeting of the McCracken County Medical Society was called to order on November 18, 1953, by George Widener, M.D., president. The minutes of the last meeting were read and approved.

James O'Brian, M.D., was introduced to the society and gave a brief talk on his present duties. Walter Johnson, M.D., reported on the progress made concerning the proposed new medical forum program. A motion was made by Eugene Sloan, M.D., and seconded by C. M. Blanton, M.D., that the medical forum be adopted as discussed. The motion carried.

J. V. Pace, M.D., discussed the present status of the blood bank. Doctors Walter Johnson, Eugene Sloan, J. V. Pace and B. N. Carle contributed to the discussion, also. E. W. Jackson, M.D., moved that the society notify the Red Cross through the Blood Bank Committee that in the society's opinion the supply of blood is inadequate for the supply of the three hospitals. The motion was seconded by B. N. Carle, M.D., and discussion followed. The motion carried.

Dr. Widener discussed cooperation by the McCracken County Medical Society with the Boy Scouts relative to furnishing medical help for one of their projects. It was moved by Dr. Sloan and seconded by T. E. Ruff, M.D., that the society cooperate to the extent of appointing members of the society to serve in the capacity of medical advisors in this group.

The floor was turned over to John Guy Miller, Louisville, field representative for the Kentucky State Medical Association, for a brief discussion of present day problems in organized medicine.

M. W. Fowler, Jr., M.D., Secretary

PIKE

The regular meeting of the Pike County Medical Association was held on November 17, 1953, at Pikeville with 18 members of the county association attending. Two guests, Mr. Roy Edwards, Williamson, West Virginia, representing the Blue-Cross, Blue-Shield plans, and Guy C. Cunningham, M.D., Ashland, were also present.

The meeting was called to order by the retiring president, T. I. Doty, M.D., Pikeville. An election of officers for the coming year was held with the following results: C. C. Rutledge, M.D., Pikeville, president; G. N. Combs, M.D., Pikeville, vice-president, and R. H. Davis, M.D., secretary-treasurer.

The members discussed plans for improving the attendance of the meetings and increasing membership of the association. Ralph Allen, M.D., Pikeville, moved that all members be required to be present at sixty per cent of the meetings throughout the year. The motion carried. In regard to this same discussion, G. N. Combs, M.D., Pikeville, moved that each member should be charged five dollars per month,

per meeting, as regular county medical association dues. These dues are to be paid regardless of whether the member attends this meeting or not, and these dues are to be paid regularly each month. Should a member get in arrears with his dues, they are to be paid before AMA and state dues are collected each year.

Discussion was held in regard to carrying out urinalysis for diabetes detection week and proper arrangements were made to take care of all individuals who desired to have urine sugar determinations.

It was recommended by the society that all dentists in the county be contacted to determine if they would enjoy attending the Pike County Medical Association meetings. If the majority of dentists are interested in attending, it was recommended that they be invited to join the Pike County Medical Association.

Guy C. Cunningham, M.D., Ashland, gave a thorough discussion covering the etiology, diagnosis and treatment of acute glomerular nephritis. Dr. Cunningham is a member of the American Board of Pediatrics.

Russell H. Davis, M.D., Secretary

TAYLOR

At a regular meeting of the Taylor County Medical Society, the following physicians were elected to take office January 1, 1954, to serve for a term of one year: W. B. Atkinson, M.D., president; M.M. Hall, M.D., vice-president; R. D. Barton, M.D., secretary.

The Kentucky Obstetrical and Gynecologic Society, under the direction of W. O. Johnson, M.D., Louisville, conducted an excellent postgraduate course for three consecutive Friday nights in Campbellsville for the physicians of this area. Dr. Johnson was assisted in the lectures and informal discussion periods by the following physicians: Doctors J. B. Marshall, Rudy Vogt, L. A. Gray, Silas Starr and Proctor Eubank.

Last spring a six-night course was offered by the Trauma Society of the American College of Surgeons under the direction of Charles Wood, M.D. All the physicians who attended these courses agree that without any exception these are among the finest meetings they have attended. The local physicians are all in favor of continuing to have two such courses each year.

Roy G. Wilson, M.D., Secretary

SHELBY-OLDHAM

The Shelby-Oldham County Medical Society held its regular meeting on Thursday, November 19, 1953, at the Old Stone Inn, near Shelbyville. The following members and guests were present:

A. D. Doak, M.D., M. D. Klein, M.D., S. B. May, M.D., W. P. McKee, M.D., L. B. Sternberg, M.D., C. C. Risk, D.D.S., A. C. Weakley, M.D., H. T. Alexander, M.D., H. B. Mack, M.D., George Ray, M.D., B. B. Sleadd, M.D., George Perrine, M.D., L. A. Wahle, M.D., J. T. Walsh, M.D., Charles Chatham, D.D.S., Don Chatham, M.D., A. M. Schoen, M.D., and C. H. Likins, Jr., M.D.

The meeting was called to order by the president, J. T. Walsh, M.D., and the minutes of the last meeting were read and approved. The secretary, C. C. Risk, D.D.S., read a letter from Edward McConnell, Louisville, of the Blue Cross - Blue Shield Plans, who asked to appear at a forthcoming meeting of the society. The secretary was instructed to invite Mr. McConnell at an early date.

Doctors Mack, Sleadd and Weakley were appointed as a nominating committee and asked to make a report at a meeting next month. Dr. Perrine introduced the guest speaker, A. M. Schoen, M.D., Louisville, who discussed "Peptic Ulcer."

C. C. Risk, D.D.S., Secretary

SCOTT

The Scott County Medical Society held its regular monthly meeting at the John Graves Ford Memorial Hospital in Georgetown, Thursday, November 8, 1953. The following members were present: Doctors F. W. Wilt, H. G. Wells, C. R. Lewis, W. S. Allphin, E. C. Barlow and H. V. Johnson.

After the minutes of the previous meeting were read and approved, Dr. Wells gave a detailed report of the transactions of the House of Delegates, which met during the Annual Meeting of the Kentucky State Medical Association. He reported that the dues to the association had been raised from $25 to $35 per year.

A motion was made and seconded that the Scott County Medical Society write a letter to the KSMA and enter a protest against raising the dues. The motion carried.

H. V. Johnson, M.D., Secretary

In Memoriam

RESOLUTION ADOPTED BY THE SHELBY-OLDHAM COUNTY MEDICAL SOCIETY ON THE PASSING OF WILLIAM HARMON NASH, M.D.

WHEREAS, the great Physician in his infinite wisdom called from our midst on September 14, 1953, William Harmon Nash, M.D., Shelbyville, Kentucky, and

WHEREAS, Dr. Nash enjoyed a long, busy and enviable career in the practice of his profession, and

WHEREAS, he was held in high esteem and respect by his colleagues and all who knew him, and

WHEREAS, he was an active member of his local and state medical associations as long as he was physically able to render service,

THEREFORE, BE IT RESOLVED, that his passing has caused in the community a regrettable loss, that his friendship and professional service in Shelby and adjoining counties has caused his friends to feel keenly his departure, that the Shelby-Oldham County Medical Society has lost an active, loyal and ethical member, and,

BE IT FURTHER RESOLVED, that this body extend to his family its sincere sympathy and consolation in their bereavement for the loss of their father and husband and that a copy of these Resolutions be spread upon the minutes of the Shelby-Oldham County Medical Society and that a copy be sent to his widow.

Committee

L. A. Whale, M.D.
H. H. Richeson, M.D.
A. C. Weakley, M.D.

HIRAM I. BLOOD, M.D.

Hazel Green

1879 - 1953

Dr. Hiram I. Blood, M.D., Hazel Green, died September 26, 1953, as the result of a freak accident at Corning, Arkansas. The 74 year old physician moved to Arkansas in August to do cancer research when his health would no longer permit him to continue his practice in Hazel Green.

Dr. Blood was buried September 30, 1953, at Middletown, Ohio, his former home. A graduate of Eclectic Medical College of Cincinnati, Ohio, in 1914, he practiced in Wolfe county until his recent move.

In addition to being a physician, Dr. Blood was also an ordained minister of the Christian Church and was known to preach an occasional sermon or officiate in a marriage ceremony.

Before his death, Dr. Blood consisted of the entire medical staff of Wolfe county's only hospital at Hazel Green. He was a member of the Wolfe County Medical Society and the Kentucky State Medical Association.

THOMAS J. CHANDLAR, M.D.

Betsy Lane

1879 - 1953

Dr. Thomas J. Chandlar, 74, Betsy Lane, died during the month of November at his home in Floyd county. He was graduated from the Hospital College of Medicine, Louisville, in 1906.

In 1920, he moved to Lackey for general practice. Later, he practiced in several counties in Eastern Kentucky including Perry, Knott and Floyd. Dr. Chandlar was a member of the Floyd County Medical Society and the Kentucky State Medical Association.

EDWARD A. ROSE, M.D.

Louisville

1919 - 1953

Dr. Edward A. Rose, 34, Louisville, died at his home, November 12, 1953, as a result of an operation he underwent September 18.

Dr. Rose was graduated from the University of Louisville School of Medicine in 1951 and interned at Gorgas Hospital, Canal Zone. He recently returned to Louisville from Alaska where he was engaged in public health service to take over the practice of his uncle, the late Edward A. Rose, M.D.

FRANK I. BUCKNER, M.D.

Campbellsville

1887 - 1953

Dr. Frank I. Buckner, 66, Campbellsville, died in the Rosary Hospital, October 13, 1953. At the time of his death, he was serving the office of president of the Taylor County Medical Society.

A graduate of the University of Louisville School of Medicine in 1913, Dr. Buckner interned at the Louisville City Hospital. After

serving as an officer in the United States Army during World War I, Dr. Buckner, a native of Taylor county, returned to Campbellsville for general practice.

He continued in private practice until 1949 when he became health officer for Taylor and Marion counties. Dr. Buckner was active throughout his life in civic, Masonic, and medical activities.

LUTHER BACH, M.D.

Florence

1891 - 1953

Dr. Luther Bach, 62, Florence, died of a heart attack at his farm estate on November 28, 1953. He had practiced in Campbell and Kenton counties for the past thirty years.

Dr. Bach was instrumental in establishing Magoffin Baptist Institute for orphans at Mount Valley, and founded the Bach Memorial Chapel in his native Breathitt county.

He served as a captain in the Army Medical Corps in World War I and with the United States Public Health Service in the Panama Canal Zone. He was a member of the Boone County Medical Society and the Kentucky State Medical Association.

WILLIAM HARMON NASH, M.D.

Shelbyville

1888 - 1953

Dr. William Harmon Nash, 65, died September 14, 1953, of a heart attack at his home in Shelbyville. For many years he was a physician associated with the Old Masons Home there.

After World War I, Dr. Nash was discharged from the Army Medical Corps, having served in France, and began practice in Shelbyville. He was graduated from the University of Louisville School of Medicine in 1912 and started practicing at Alton in Anderson County. Later he moved to Bagdad and then to Finchville, in Shelby County.

WASHINGTON NEWS DIGEST

(Continued from Page 53)

government paying all but a token of the cost. At its December meeting, the AMA's House of Delegates proposed that in this country the military provide medical care for dependents only where private facilities are not adequate.

Also up for decision this year is a Defense Department's proposal that the federal government furnish medical, dental and nursing scholarships, with the recipients obligated for government service at the rate of one year for every year of the scholarship.

There is a strong possibility of pressure to enact a program under which the federal government would in one way or another subsidize private health insurance plans. The idea is known to interest Rep. Charles Wolverton (R., N. J.), chairman of the House Interstate and Foreign Commerce Committee, which last fall conducted a series of hearings on health matters. Senators Ives (R., N. Y.) and Flanders (R., Vt.) are offering a bill along the same lines in the Senate.

The controversial Bricker resolution holds over from the last session, and may receive early consideration in the Senate. Senator Bricker believes that Congress should have some check on the President's treaty-making powers. The American Medical Association repeatedly has indorsed the Bricker resolution as a safeguard against the introduction into this country by treaty of government-controlled medical plans without Congress itself having a chance to pass on them.

Awaited with interest in Washington are the findings of two Commissions appointed last year to look into the relationships between the federal government on the one hand and state and local governments on the other, and to investigate operations of the executive branch. The former is headed by Clarence Manion and the latter by former President Hoover. The Hoover Commission has until next year to make its report. The Manion Commission was instructed to have a report ready by March, but it may ask for more time.

The American Medical Association is offering a 13-day Hawaiian Holiday Tour for physicians and their wives who plan to attend the annual AMA convention in San Francisco, June 21-25, 1954, according to George F. Lull, M.D., secretary and general manager of the AMA. The guests will stay at the beautiful Royal Hawaiian Hotel on Waikiki Beach during their visit to the Islands. Reservations may be made through W. M. Maloney, general agent, Room 711, 105 West Adams Street, Chicago, Illinois.

BOOK REVIEWS

MAY'S MANUAL OF DISEASES OF THE EYE, 21st Edition, by Charles A. Perera, M.D., Associate Clinical Professor, College of Physicians and Surgeons, Columbia University, Williams & Wilkins Co., Baltimore, 1953, pp 512, 378 Figures, $6.00.

The appearance of a 21st American edition of this well organized and succinct ophthalmic classic is mute evidence of its value through 53 years. Eleven British and 43 other editions in 9 foreign languages confirm its wide appeal to the student and general physician for whom it is written. The arrangement continues to devote adequate but unlabored space to examining methods and refraction. The visual apparatus is considered according to anatomical subdivisions. Major diseases affecting each region are principally discussed according to signs and symptoms and to treatment, but smaller paragraphs concerning etiology and pathology are routinely included. Less common entities are described in lower case type. There are a large number of helpful illustrations. Chapters on well known therapeutic agents and general diseases are clear and terse without appraising subjects which have not borne the test of several years.

A few minor anachronisms such as slitting of the tear point (p 79), the use of yellow oxide of mercury (p 49), and reference to candles in examining technique detract from a 1953 revision. Chauvinistically, we regret to see (p 123) present day Kentucky incorrectly listed as an area in which trachoma is "fairly common."

With remarkable economy of words, the book continues to be a compact and comprehensive guide to the student and non-ophthalmologist.

Reviewed by Arthur H. Keeney, M.D.

THERAPEUTICS IN INTERNAL MEDICINE, 2nd Edition by Franklin A. Kyser, M.D., F.A.C.B., Assistant Professor of Medicine, Northwestern University Medical School, Paul B. Hoeber, Inc., Harper & Brothers, 1953, pp 763, with Appendix.

"Therapeutics in Internal Medicine," written by 84 authorities, covers the vast field of medical therapy in 763 pages of readily readable two column type.

The book is divided into 18 chapters, each of which deals with a specific group of diseases and ther treatment. Sub-grouped under the various chapters are the specific disease entities which are in general admirably introduced and discussed by authorities of the various fields. A comprehensive plan of therapy is offered for each entity.

Chapter XVI contains an extremely well written subdivision on "A Therapeutic Approach to Psychosomatic Problems" and is well worth reading. The appendix contains a section of the more commonly used diets, and the index is complete, well organized and easy to use.

Like all books on therapeutics, progress in many fields is so rapid that it is almost impossible to keep up to date in all fields. Some such instances are (1) failure to discuss Segmental Resection under treatment of tuberculosis, (2) omission of discussion of Regitine Test for pleochromocytoma, (3) omission of the newer anticholinergic drugs, (4) no mention of Peritrate in treatment of angina pectoris.

Under Pulmonary Embolism there is an excellent review of prophylaxis. Anticoagulant therapy here is not too clear. The author speaks of "prothrombin concentration" and not prothrombin time or activity. He lists the average dose of dicumarol at 200 mgm. which is obviously high. In contrast to this, the section of Coronary Heart Disease outlines a more complete method of anticoagulant therapy.

The section on antibiotics is remarkably up to date. Streptomycin is listed as the antibiotic of choice for Klebsiella pneumonia, and this is perhaps a bit misleading. Parasitic diseases give a very complete program for treatment of the individual cases with all indications, contraindications, methods and dosages well outlined.

The section on gastroenterology has detailed charts for ulcer therapy. For bleeding ulcers the author prefers to defer X-ray until bleeding has stopped. Post-operative complications of ulcer surgery are scantily discussed with only a casual mention of that common problem known as the dumping syndrome.

For bronchitis and bronchiectasis there is a good outline of aerosol therapy. In discussing emphysema all treatments are mentioned only to be discarded. "Breathing exercises are of real value" is stated, but no further explanation is listed on this singular method of treatment which offers hope.

Sections on Poisonings, Arthritis, Epilepsy, and Hematologic Disorders are complete and detailed. In spite of the few isolated omissions or criticisms listed above the book is an excellent reference and one which would prove to be of value in every practitioner's office. The sections are all clearly written and to the point. In this book one readily finds specific answers to one's therapeutic problems.

Reviewed by George W. Pedigo, Jr., M.D.

CONSTITUTION AND BY-LAWS

of the

KENTUCKY STATE MEDICAL ASSOCIATION

1953-1954

1953 - 1954

CONSTITUTION AND BY-LAWS OF THE KENTUCKY STATE MEDICAL ASSOCIATION

CONSTITUTION

Article I. Name of the Association
Article II. Purpose of the Association
Article III. Component Societies
Article IV. Composition of the Association
Article V. House of Delegates
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Article VII. Sessions and Meetings
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BY-LAWS

Chapter I. Membership
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Chapter III. General Meeting
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Chapter V. Election of Officers
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Chapter VII. The Council
Chapter VIII. Committees
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Chapter XIII. Amendments

CONSTITUTION

Article I. Name of the Association

The name and title of this organization shall be the Kentucky State Medical Association.

Article II. Purpose of the Association

The purpose of the Association shall be to federate and bring into compact organization the entire medical profession of the State of Kentucky and to unite with similar associations in other states to form the American Medical Association, with a view to the extension of medical knowledge, and to the advancement of medical science, to the elevation of the standard of medical education and to the enactment and enforcement of just medical laws; to the promotion of friendly intercourse among physicians and to the guarding and fostering of their material interest and to the enlightenment and direction of public opinion in regard to the great problem of state medicine so that the profession shall become more capable and honorable within itself and more useful to the public in the prevention and cure of disease and in prolonging and adding comfort to life.

Article III. Component Societies

Component societies shall consist of those county medical societies which hold charters from this Association.

Article IV. Composition of the Association

The Association shall consist of the members of the component societies as defined in the By-Laws.

Article V. House of Delegates

Section 1. The House of Delegates shall be the legislative and business body of the Association.

Section 2. Delegates shall be members of and elected by component societies in accordance with the By-Laws. Officers of the Association and Delegates to the American Medical Association and the five immediate Past-Presidents shall be ex-officio members of the House of Delegates and entitled to vote.

Section 3. The Speaker or Vice-Speaker shall preside during the meetings of the House of Delegates. The Presiding Officer shall not be entitled to a vote except in the event of a tie vote.

Section 4. The House of Delegates shall be the final judge as to the qualification of its members.

Article VI. Sections and District Societies

The House of Delegates may provide for a division of the scientific work of the Association into appropriate Sections and for the organization of such Councilor District Societies as will promote the best interest of the profession, such societies to be composed exclusively of members of component county societies.

Article VII. Sessions and Meetings

The Association shall hold an annual session and such special sessions as may be desirable in accordance with the By-Laws of the Association.

Article VIII. Officers

Section 1. The Officers of this Association shall be a President, a President-Elect, three Vice-Presidents, a Secretary, a Treasurer, a Speaker and Vice-Speaker of the House of Delegates, and a Councilor from each Councilor District that may be established and such other Officers as provided for in the By-Laws.

Section 2. The Officers of the Association shall serve for the term of office and subject to provisions as specified in the By-Laws.

Section 3. All Officers shall serve until their successors have been elected and installed.

Section 4. The Officers of the Association shall be elected at the last session of the House of Delegates at the annual session of the Association and shall take office on that day unless otherwise specified.

Article IX. Funds and Expenses

Funds for meeting the expenses of the Association shall be arranged for by the House of Delegates by an equal per capita assessment upon each county society to be fixed by the House of Delegates by voluntary contribution and from the profits of its publication. Funds may be appropriated by the House of Delegates to defray the expenses of the Annual Session, for publication and for such other purposes as will promote the welfare of the Association and profession.

Article X. Referendum

The General Meeting of the Association may, by a two-thirds vote, order a general referendum upon any question pending before the House of Delegates, and the House of Delegates may, by a similar vote of its own members or after a like vote of the General Meeting, submit any such question to the membership of the Association for a final vote; and if the persons voting shall comprise a majority of all the members, a majority of such vote shall determine the question and be binding upon the House of Delegates.

Article XI. The Seal

The Association shall have a common Seal with power to break, change or renew the same at pleasure.

Article XII. Amendments

The House of Delegates may amend any article of this Constitution by a two-thirds vote of the delegates registered at that Annual Session, provided that such amendment shall have been presented in open meeting at the previous Annual Session, and that it shall have been sent officially to each component county society at least two months before the session at which final action is to be taken.

BY-LAWS

Chapter I. Membership

Section 1. A member of this Association must be a member of one of the component societies and when certified to the Secretary of the Association as a member of a component society, properly classified as to type of membership, and when the dues pertaining to his membership classification have been received by the Secretary of the Association the name of the member shall be included in the official roster of the Association and the member shall be entitled to all the privileges of his class membership.

Section 2. Active Members. Active members shall comprise the active members of the component medical societies. To be eligible for active membership in any component county society the applicant must be:

A. A doctor of medicine who is licensed to practice medicine in the State of Kentucky and who is of good moral and professional standing.

B. A medical officer of the United States Army, Navy, Air Force, Veterans Administration, Public Health Service, or other governmental service while on duty in the State.

C. Any doctor of medicine engaged in scientific or professional pursuits whose principles and ethics are consonant with those of the State Association.

Section 3. Associate Members. Associate members shall consist of associate members of the component medical societies who are not eligible for active membership and who are qualified under one or more of the following groups:

A. An intern, resident or teaching fellow who is a Doctor of Medicine but who is not licensed to practice medicine in the state.

B. A person who is not a Doctor of Medicine but who is engaged in scientific, professional or other pursuits, whose principles and ethics are consonant with those of the Association.

C. A Doctor of Medicine residing and practicing outside the area covered by the component society and who is an active member in good standing in his own component society.

Associate members shall not have the right to vote nor to hold office. The Council shall, from time to time, determine the amount of dues to be charged. Associate members shall receive the Journal and the publications of the Association.

Section 4. Emeritus Members. Component societies may elect as a Member Emeritus any Doctor of Medicine who has retired from active practice and who has previously maintained active membership in good standing in his society. Emeritus members shall not have the right to vote nor to hold office and shall not pay dues. They shall receive the Journal and other publications of the Association.

Section 5. Student Members. Any student in an accredited medical school in Kentucky

or any resident of Kentucky who is a student in an accredited medical school in the United States shall be eligible for student membership. Student members shall not have the right to vote nor hold office. They may apply directly to the State Association for membership and be assigned to the county society of their choice. The Council shall determine, from time to time, the amount of dues to be charged. Student members shall receive the Journal of the Association. The membership year for student members shall run from September 1 to August 31 of each year.

Section 6. Honorary Members. Any physician possessed of scientific attainments who is a member of a constituent State Medical Association and who has participated in the program of the Scientific Session and who is not a citizen of Kentucky may by unanimous vote of the House of Delegates be elected to honorary membership. Honorary members shall be entitled to the privilege on the floor in all scientific sessions.

Section 7. Guests of Honor. Any distinguished physician not a resident of this State may become a guest of honor during any annual session upon invitation of the Association or its Council and shall be accorded the privilege of participating in all of the scientific work of that session.

Section 8. The name of a physician upon the properly certified roster of members or list of delegates, of a chartered county society which has paid its annual assessment, shall be prima facie evidence of his right to register at the Annual Session in the respective bodies of this Association.

Section 9. No persons who are under sentence of suspension or expulsion from any component society of this Association, or whose name has been dropped from its rolls of membership shall be entitled to any of the rights or benefits of this Association, nor its proceedings until such time as he has been relieved of such liability.

Section 10. Each member in attendance at the Annual Session shall enter his name on the registration book indicating the component society of which he is a member. When his right to membership has been verified by reference to the roster of the society, he shall receive a badge which shall be evidence of his right to all the privileges of membership at that session. No member or delegate shall take part in any of the proceedings of an annual session until he has complied with the provision of this section.

Chapter II. Annual and Special Sessions of The Association

The Association shall hold an annual session and such special sessions at such time and place as may be determined by the House of Delegates.

Chapter III. General Meeting

The General Meeting shall include all registered active members, associate members and guests. Associate members and guests shall not have the right to vote on pending questions, but shall have equal rights with active members to participate in the proceedings and discussions. Each General Meeting shall be presided over by the President or in his absence or disability or upon his request, by one of the Vice-Presidents. Before it, at such time and place as may have been arranged, shall be delivered the annual address of the President, and the entire time of the sessions as far as may be, shall be devoted to papers and discussions relating to scientific medicine.

Chapter IV. House of Delegates

Section 1. The House of Delegates shall meet annually at the time and place of the Annual Session of the Association and shall so fix its hours of meeting as not to conflict with the first General Meeting of the Association, or with the meeting held for the address of the President so as to give delegates an opportunity to attend the other scientific proceedings and discussions so far as is consistent with their duties. But if the business interest of the association and profession require, it may meet in advance or remain in session after the final adjournment of the General Meeting. The House of Delegates may be called into special session by the President with the approval of the Council and a special session of the House of Delegates shall be called by the President on a written request of the delegates representing fifty or more component county societies. When such special session is called, the Secretary shall mail a notice of the time and place and purpose of such meeting to the last known address of each member of the House of Delegates at least ten days before such special session.

Section 2. In the event there is no duly authorized delegate in attendance at the regular meeting of the House of Delegates the President shall consult any duly elected officer of the component society who is in attendance and with the approval of the Credentials Committee may appoint any active member of the component society in attendance at the meeting as the delegate. In the event there is no duly elected officer of the component society in attendance, the President may make the said appointment with the approval of the Credentials Committee. All appointments made

shall also be with the approval of the House of Delegates.

Section 3. A majority of the registered delegates shall constitute a quorum and all of the meetings of the House of Delegates shall be open to members of the Association. The House of Delegates shall have the right to go into executive session whenever such action is indicated in the judgment of the House of Delegates, except that active members of the Association shall have the right to attend all executive sessions.

Section 4. From among the members of the House of Delegates the Speaker of the House of Delegates shall appoint a Committee on Credentials, Rules and Order of Business, Report of Officers and the Council, Report of Standing Committees, Report of Special Committees, Report of Advisory Committees, Resolutions, Miscellaneous Business, Revision of By-Laws and Constitution, and such other committees as he may deem necessary, as well as Tellers and Sergeant-At-Arms. All appointments by the Speaker of the House of Delegates are subject to approval by the House of Delegates.

Section 5. Each Resolution introduced into the House of Delegates shall be in writing and presented to the Secretary. Immediately after the Delegate has introduced the Resolution, it shall be referred to the proper Reference Committee before action thereon is taken.

Section 6. No new business shall be introduced in the last meeting of the House of Delegates without unanimous consent of the Delegates except when presented by the Council. All new business so presented shall require three-fourths affirmative vote for adoption.

Section 7. It shall, through its officers, Advisory Council, and otherwise, give diligent attention to and foster the scientific work and spirit of the Association, and shall constantly study and strive to make each Annual Session a stepping stone to further ones of higher interest.

Section 8. It shall consider and advise as to material interest of the profession, and of the public in those important matters wherein it is dependent upon the profession, and shall use its influence to secure and enforce all proper medical and public health legislation, and to diffuse popular information in relation thereto.

Section 9. It shall make careful inquiry into the condition of the profession of each county in the State, and shall have authority to adopt such methods as may be deemed most efficient for building up and increasing the interest in such county societies as already exist and for organizing the profession in counties where societies do not exist. It shall especially and systematically endeavor to promote friendly intercourse between physicians of the same locality and shall continue these efforts until every physician in every county of the State who can be made reputable, has been brought under medical society influence.

Section 10. It shall encourage postgraduate work in medical centers as well as home study and research and shall endeavor to have the results of the same utilized and intelligently discussed in the county societies.

Section 11. It shall elect representatives to the House of Delegates of the American Medical Association in accordance with the Constitution and By-Laws of that body.

Section 12. It shall upon application provide and issue charters to county societies organized to conform to the spirit of the Constitution and By-Laws.

Section 13. In sparsely settled sections two or more County Societies may join for scientific programs, the election of officers, and such other matters as they may deem advisable. The County Society thus combined shall not lose any of its privileges and representation. The active members of each County Society shall annually elect at least a Secretary and a Delegate for the transaction of its business with the State Association.

Section 14. The state shall be divided into the following councilor districts:

No. 1—Ballard, Calloway, Carlisle, Fulton, Graves, Hickman, Livingston, McCracken and Marshall.

No. 2—Daviess, Hancock, Henderson, McLean, Ohio, Union and Webster.

No. 3—Caldwell, Christian, Crittenden, Hopkins, Lyon, Muhlenberg, Todd and Trigg.

No. 4—Breckinridge, Bullitt, Grayson, Green, Hardin, Hart, Larue, Marion, Meade, Nelson, Spencer, Taylor and Washington.

No. 5—Jefferson.

No. 6—Adair, Allen, Barren, Butler, Cumberland, Edmonson, Logan, Metcalfe, Monroe, Simpson and Warren.

No. 7—Anderson, Carroll, Franklin, Gallatin, Grant, Henry, Oldham, Owen, Shelby and Trimble.

No. 8—Boone, Campbell and Kenton.

No. 9—Bath, Bourbon, Bracken, Fleming, Harrison, Mason, Nicholas, Pendleton, Scott and Robertson.

No. 10—Fayette, Jessamine and Woodford.

No. 11—Clark, Estill, Jackson, Lee, Madison, Menifee, Montgomery, Owsley, Powell and Wolfe.

No. 12—Boyle, Casey, Clinton, Garrard, Lincoln, McCreary, Mercer, Pulaski, Rockcastle, Russell and Wayne.

No. 13—Boyd, Carter, Elliott, Greenup, Lawrence, Lewis, Morgan and Rowan.

No. 14—Breathitt, Floyd, Johnson, Knott, Letcher, Magoffin, Martin, Perry and Pike.

No. 15—Bell, Clay, Harlan, Knox, Laurel, Leslie and Whitley.

Councilor district meetings may be held as desired, and District Medical Associations may be organized as desired according to the districts outlined above.

Section 15. It shall have authority to appoint committees for special purposes from among members of the Association who are not members of the House of Delegates and such committees may report to the House of Delegates in person, and may participate in the debate thereon.

Section 16. It shall approve all memorials and resolutions issued in the name of the Association before the same shall become effective.

Section 17. A digest of proceedings of the House of Delegates shall be published in the Journal of the Association.

Chapter V. Election of Officers

Section 1. The President-Elect and the Vice-Presidents shall be elected for a term of one year. The Speaker and Vice-Speaker of the House of Delegates shall be elected for a term of three years. The Secretary and Treasurer shall be elected for a term of five years. The Councilors shall be elected for a term of three years and shall be limited to serving for not more than two consecutive terms. The terms shall be so arranged that one-third of the terms expire each year, insofar as possible. No member shall be eligible for the office of President, President-Elect, Vice-President, Speaker or Vice-Speaker of the House of Delegates, or Councilor who has not been an active member of the Association for at least five years.

Section 2. All elections shall be by secret ballot, and a majority of the votes cast shall be necessary to elect, provided, however, that when there are more than two nominees the nominee receiving the least number of votes on the first ballot shall be dropped and the balloting continue until an election occurs in like manner.

Section 3. Any member known to have directly or indirectly solicited votes for, or sought any office within the gift of this Association shall be ineligible for any office for two years.

Section 4. The election of officers shall be held during the closing session at the regular annual meeting of the House of Delegates.

Section 5. During the last session of the House of Delegates the Speaker of the House of Delegates shall submit to the members of the House of Delegates a list of ten names from which by ballot the House of Delegates shall select five members to serve as the nominating committee for the next year. The five names receiving the most votes shall form the committee. The Committee shall select one of its members as Chairman. The nominating committee shall submit its report in writing to all members of the House of Delegates at the first meeting of the House of Delegates and shall submit one or more names for each officer to be elected. Additional nominations may be made from the floor by submitting the nomination without discussion or comment.

Section 6. The Delegates from the counties in each Councilor District shall form the Nominating Committee for the purpose of nominating a Councilor for the Councilor District concerned. This committee shall hold a meeting open to all active members of Councilor District concerned who are in attendance at the meeting for the purpose of discussing the nomination for the Councilor to serve the District. Additional nominations may be made from the floor by any member of the House of Delegates when the Nominating Committee makes its report to the House of Delegates.

Chapter VI. Duties of Officers

Section 1. The President shall preside at all general meetings of the Association and shall appoint all committees not otherwise provided for. He shall deliver an annual address at such time as may be arranged and shall perform such other duties as custom and parliamentary usage may require. He shall be the real head of the profession of the State during his term of office and so far as practicable, shall visit by appointment, the various sections of the State and assist the Councilors in building up the county societies and in making their work more practical and useful.

Section 2. The President-Elect shall be a member of the Committee on Scientific Assembly. He shall become President of the Association at the next annual meeting of the Scientific Session following his election as President-Elect. He shall assist the President in visitation of county and other meetings and shall be ex-officio a member of the House of Delegates with the right to vote. In event of death, resignation, or if he becomes permanently disqualified, his successor shall be elected by the House of Delegates and shall be installed as President of the Association at the next annual meeting of the Scientific Session of the Association.

Section 3. The Vice-Presidents shall assist the President in the discharge of his duties. In the event of his death, resignation or re-

moval, the Council shall elect one of the Vice-Presidents to succeed him.

Section 4. The Speaker of the House of Delegates of the Association shall preside at all meetings of the House of Delegates. He shall appoint all committees for the House of Delegates with the approval of the House of Delegates. He shall be an ex-officio member of all said committees. He shall perform such other duties as custom and parliamentary usage may require.

Section 5. The Vice-Speaker shall assume the duties of the Speaker in his absence, and shall assist the Speaker in the performance of his duties. In the event of the death, resignation or removal of the Speaker, the Vice-Speaker shall automatically become Speaker of the House of Delegates.

Section 6. The Treasurer shall give bond for the trust imposed in him whenever the House of Delegates shall deem it requisite. He shall demand and receive all funds due the Association, together with the bequests and donations. He shall, under the direction of the House of Delegates, sell or lease any real estate belonging to the Association and execute the necessary papers and shall in general subject to such direction have the care and management of the fiscal affairs of the Association. All vouchers of the Association shall be signed by the Secretary or his Executive Secretary and shall be counter-signed by the Treasurer of the Association. Under unusual circumstances, when one or more of the above named officials are not readily available, the President of the Association or the Chairman of the Council is authorized to sign the vouchers, provided that in any event all vouchers of the Association shall bear a signature and a counter-signature. All five officials shall be required to give bond in an amount to be determined by the Council. The Treasurer shall subject his accounts to an annual audit under the direction of the Council. He shall render an annual account of his doings and the state of all Association funds.

Section 7. The Secretary, acting with the Committee on Scientific Assembly, shall prepare and issue the program for and attend all meetings of the Association and of the House of Delegates and he shall keep minutes of their respective proceedings in separate record books. He shall charge upon his books the assessments against each component county society at the end of the fiscal year; he shall collect and make proper credits for the same and perform such other duties as may be assigned him. He shall be custodian of all record books and papers belonging to the Treasurer, and shall keep account of and promptly turn over to the Treasurer all funds of the Association which may come into his hands. He shall provide for the registration of the members and delegates at the Annual Session. He shall keep a card index register of all practitioners of the State by counties, noting on each his status in relation to his county society and upon request shall transmit a copy of this list to the American Medical Association for publication. In so far as it is in his power he shall use the printed matter, correspondence and influence of his office to aid the Councilors in the organization and improvement of the county societies and in extension of the power and usefulness of this Association. He shall conduct the official correspondence, notify members of meetings, officers of their election, and committees of their appointments and duties. He shall be editor of the Kentucky Medical Journal. He shall employ such assistants as may be ordered by the Council or the House of Delegates. He shall annually make a report of his doings to the House of Delegates.

In order that the Secretary may be enabled to give that amount of his time to his duties which will permit of his becoming proficient, it is desirable that he shall receive some compensation. The amount of his salary shall be fixed by the House of Delegates.

Chapter VII. The Council

Section 1. The Council shall be the executive body of the House of Delegates and between sessions of the House of Delegates shall exercise the powers conferred on the House of Delegates by the Constitution and By-Laws. The Council shall consist of the duly elected councilors. The President, the President-Elect, the immediate Past-President, the Speaker and Vice-Speaker of the House of Delegates, the Secretary, the Treasurer and the Delegates to the American Medical Association shall be ex-officio members of the Council with the right to vote. The Executive Committee of the Council shall consist of the President, the President-Elect and the Secretary of the Association, together with the Chairman of the Council, Vice-Chairman of the Council and two additional councilors to be elected annually by the Council.

Section 2. The Council shall hold daily meetings during the annual session of the Association and at such other times as necessity may require, subject to the call of the Chairman or on petition of three councilors. It shall meet on the last day of the Annual Session of the Association for reorganization and for the outlining of the work for the ensuing year. At this meeting it shall elect a chairman and secretary, and it shall keep a permanent record of its proceedings. It shall, through its Chair-

man, make an annual report to the House of Delegates at such time as may be provided, which report shall include an audit of the account of the Secretary and Treasurer and other agents of this Association and shall also specify the character and cost of all the publications of the Association during the year, and the amounts of all other property belonging to the Association, or under its control, with such suggestions as it may deem necessary. In the event of a vacancy in any office the Council may fill the same until the annual election.

Section 3. Each Councilor shall be organizer, peacemaker and censor for his district. He shall visit each county in his district at least once a year for the purpose of organizing component societies where none exist, for inquiring into the condition of the profession and for improving and increasing the zeal of the county societies and their members. The necessary traveling expenses incurred by Councilor in the line of his duties herein imposed may be allowed by the House of Delegates upon a proper itemized statement, but this shall not be construed to include his expense in attending the Annual Session of the Association.

Section 4. Collectively the Council shall be the Board of Censors of the Association. It shall consider all questions involving the right and standing of members, whether in relation to other members, to the component societies or to this Association. All questions of an ethical nature brought before the House of Delegates of the General Meeting shall be referred to the Council without discussion. It shall hear and decide all questions of discipline affecting the conduct of members or a county society upon which appeal is taken from the decision of an individual Councilor. Its decision in all such cases shall be final.

Section 5. The Council shall have the right to communicate the views of the profession and of the Association in regard to health, sanitation and other important matters to the public and the lay press. Such communications shall be signed by the President of the Association and the Chairman of the Council as such.

Section 6. The Council shall provide for and superintend the publication and distribution of all proceedings, transactions and memoirs of the Association and shall have authority to appoint such assistants to the editors as it deems necessary. It shall manage and conduct the Kentucky Medical Journal, which is the organ of the Association, and all money received by the Journal, the Councilor or any officer of the Association, shall be paid to the Treasurer of the Association on the first of each month.

Section 7. All reports on scientific subjects and all scientific discussions and papers read before the Association shall be referred to the Kentucky Medical Journal for publication. The editor, with the consent of the Councilor for the District in which he resides, may curtail or abstract papers or discussions, and the Council may return any paper to its author which it may not consider suitable for publication.

Section 8. All commercial exhibits during the Annual Session shall be within the control and direction of the Council.

Section 9. In the event the office of one of the District Councilors is vacated between the meetings of the House of Delegates, the President of the Association may call a meeting of the delegates of record in the Headquarters Office from the counties of that district for the purpose of submitting one or more nominees as candidates to fill the office until the next meeting of the House of Delegates. The name or names of the nominee or nominees shall be submitted to the Council, which will elect a Councilor from them to serve until the next meeting of the House of Delegates.

Chapter VIII. Committees

Section 1. The Standing Committees shall be as follows:

A Committee on Arrangements
A Committee on Scientific Assembly
A Committee on Public Relations
A Committee on Medical Service
A Committee to Study Constitution and By-Laws
A Medico-Legal Committee

and such other committees as may be necessary. The Headquarters Office at 620 South Third Street, Louisville 2, Kentucky, shall be the headquarters for all committees and activities of the Association except as may be specifically authorized by the Executive Committee. Committees shall be appointed by the President of the Association in conference with the Secretary unless otherwise specified. The President, Secretary and General Manager, and Executive Secretary shall be ex-officio members of all committees serving without power to vote except as otherwise specified.

Section 2. The Committee on Arrangements shall consist of as many members and subcommittees as are appointed by the President of the Association. No county medical society as such shall serve as the host society. The Chairman shall report an outline of the arrangements to the Secretary for publication in the program and shall make such announcements from time to time as may be desired. All expenses of the Committee on Arrangements shall be paid out of the funds of the Association that are made available for that purpose.

Section 3. The Committee on Scientific Assembly shall consist of five members. The President of the Association shall be a member and Chairman of the Committee. The Presi-

The Problem of Nausea and Vomiting:

ITS TREATMENT WITH DRAMAMINE®

Whenever nausea, vomiting and vertigo are disturbing and complicating factors, Dramamine may be used with confidence.

Keats[1] outlines the wide list of conditions in which Dramamine (brand of dimenhydrinate) has proved valuable as follows: "It has been well established in the control of motion sickness. It has been used effectively in the prevention and treatment of seasickness, airsickness, [in the treatment of] the nausea of pregnancy, Ménière's syndrome, . . . radiation sickness . . . and postfenestration reactions. . . . The site of action is imperfectly understood, but there is indication of an action of depressing labyrinthine function or its neural pathways, a highly selective central action, or both. Few side reactions of this drug have been noted."

The usual dose for motion sickness is 50 mg. (one tablet) taken one-half hour before departure and, if necessary, before meals for the duration of the journey. Control of nausea and vomiting of other conditions and severe motion sickness is achieved, with minimal drowsiness, by a dosage of 100 mg. every four hours.

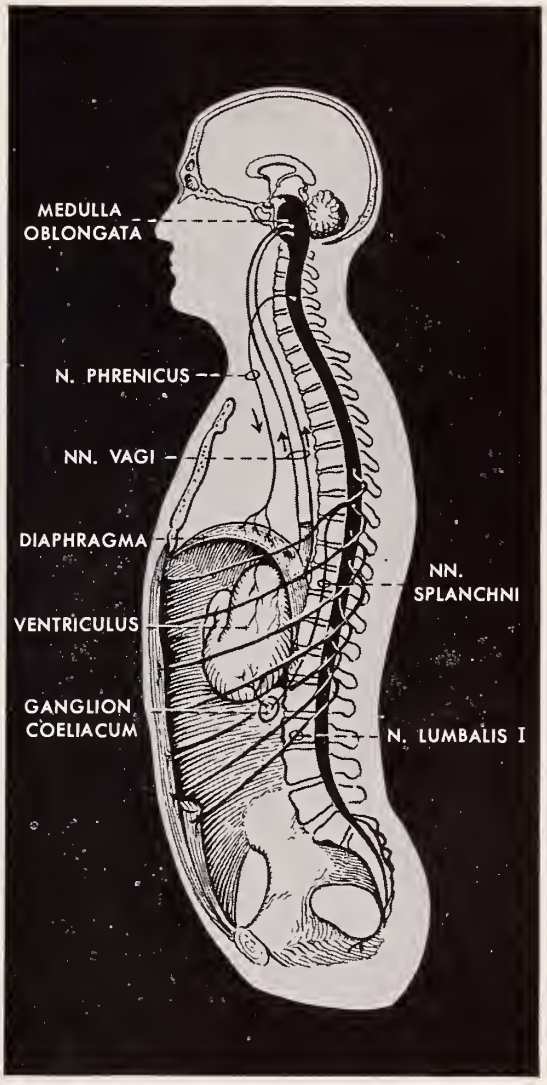
"[Dramamine] is administered orally or rectally. . . . The same doses may be administered rectally by insertion of the tablet or other suitable form. . . ."[2]

Dramamine Liquid is particularly useful for children.

Dramamine is accepted by the Council on Pharmacy and Chemistry of the American Medical Association.

1. Keats, S.: Ataxic Cerebral Palsy with Akinetic Seizures: Dramatic Response to Dramamine, J. M. Soc. New Jersey *50*:53 (Feb.) 1953.

2. Council on Pharmacy and Chemistry: New and Nonofficial Remedies, 1953. Philadelphia, J. B. Lippincott Company, 1953, p. 471.



THE VOMITING REFLEX: *Vagus→ nodose ganglion→ solitary tract→ spinal cord→ cervical, thoracic and lumbar nerves to diaphragm, cardiac sphincter, stomach, abdominal and pelvic musculature. (After Krieg, W. J. S.: Functional Neuroanatomy, ed. 2, New York, The Blakiston Company, Inc., 1953, p. 104.)*

SEARLE *Research in the Service of Medicine*

dent-Elect shall be a member of the Committee. The President of the Association shall appoint one member for a three-year term. The Committee shall determine the character and scope of the scientific proceedings of the Association, subject to the provisions or the instructions of the House of Delegates or of the Association or to the provisions of the Constitution and By-Laws. Thirty days previous to each annual session it shall prepare and issue a program announcing the order in which papers, discussions and other business shall be presented which shall be adhered to by the Association as nearly as practicable.

Section 4. The Committee on Public Relations shall consist of five members appointed by the Council of the Association. The members shall be appointed for a term of three years each, which shall be staggered insofar as possible. The Chairman of the Committee shall be designated by the Council. Under the direction of the Council it shall represent the Association in securing and enforcing legislation in the interest of Public Health and scientific medicine. It shall keep in touch with the profession and public opinions, shall endeavor to shape legislation so as to secure the best results for the whole people and shall utilize every organized influence in local, state and national affairs and elections. Its work shall be done with dignity becoming a great profession and with that wisdom which makes effective its work and influence. It shall have authority to be heard before the entire Association upon questions of great concern at such times as may be arranged during the annual session.

Section 5. The Committee on Medical Service shall consist of five members appointed by election of the Council. The terms of each member shall be for three years and shall be staggered insofar as possible. The Council shall annually designate the Chairman of the committee. It shall be concerned with and responsible for all matters of Medical Education and Medical Economics which shall be within the province of the State Medical Association. It shall continually strive to serve as a liaison between the public and the Medical Association in these matters.

Section 6. The Medico-Legal Committee shall consist of three members, one of whom, the Chairman, shall be elected by the Council for five years, and the Secretary and Treasurer shall be the other two members ex-officio. This Committee shall select and fix the compensation for an attorney, who shall act as general counsel, and if required, additional local counsel. The Association through this Committee shall defend its members who are in good standing against unjust suits for malpractice.

Section 7. The Committee to Study the Constitution and By-Laws shall make a constant study of the Constitution and By-Laws. The committee shall annually make a recommendation concerning changes which it feels should be made in order to keep the Constitution and By-Laws in line with changing conditions and circumstances.

Chapter IX. Assessments and Expenditures

Section 1. The assessment of thirty five dollars per capita on the membership of the component societies is hereby made the annual dues of this Association. The Secretary of each county society shall forward its assessment together with its roster of all officers and members, list of delegates, and list of non-affiliated physicians of the county to the Secretary of this Association on the first day of January in each year.

Section 2. Any county society which fails to pay its assessments, or make the report required, on or before the first day of April in each year, shall be held as suspended and none of its members or delegates shall be permitted to participate in any of the business or proceedings of the Association or of the House of Delegates until such requirements have been met.

Section 3. All motions and resolutions appropriating money shall specify a definite amount or so much thereof as may be necessary for the purpose, and must have the prior approval of the Council before they can become effective.

Chapter X. Rules of Conduct

The principles set forth in the Principles of Ethics of the American Medical Association shall govern the conduct of members in their relation to each other and to the public.

Chapter XI. Rules of Order

The deliberations of this Association shall be governed by parliamentary usage as contained in Robert's Rules of Order, unless otherwise determined by a vote of its respective bodies.

Chapter XII. County Societies

Section 1. All county societies now in affiliation with the State Association or those that may hereafter be organized in this State, which have adopted principles of organization not in conflict with this Constitution and By-Laws shall upon application to the House of Delegates, receive a charter from and become a component part of this Association.

Section 2. As rapidly as can be done after the adoption of this Constitution and By-Laws, a medical society shall be organized in every county in the state in which no component society exists, and charters shall be issued thereto.

Section 3. Charters shall be issued only upon approval of the House of Delegates and



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Norton's entire medical staff and services are available to patients. Vitamin, calcium, antabuse, high caloric diet and other therapies are used as indicated.



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Consultation with Norton's Psychiatric Department—affiliated with the University of Louisville on a post-graduate teaching basis—is available both to the patient and family physician. A lay therapist, trained at the Yale and Wisconsin schools for study of alcohol, is on full-time duty; the hospital also cooperates closely with Alcoholics Anonymous.



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shall be signed by the President and Secretary of this Association. The House of Delegates shall have authority to revoke the charter of any component county society whose actions are in conflict with the letter or spirit of this Constitution and By-Laws.

Section 4. Only one component society shall be chartered in any county except that the House of Delegates may issue a charter to one state-wide society of worthy Negro physicians who are not members of any county society. Membership in the component society thus created shall entitle the members thereof to all the rights and benefits of membership in the Kentucky State Medical Association. When more than one county society exists friendly overtures and concessions shall be made with the aid of the Councilor of the District if necessary and all of the members brought into one organization. In case of failure to unite, an appeal may be made to the Council, which shall decide what action shall be taken.

Section 5. Each county society shall judge of the qualifications of its own members, but as such societies are the only portals to this Association every reputable and legally registered physician who is practicing, or who will agree to practice nonsectarian medicine shall be entitled to membership. Before a charter is issued to any county society, full and ample notice and opportunity shall be given to every physician in the county to become a member.

Section 6. Any physician who may feel aggrieved by the action of the society of the county in refusing him membership, or in suspending or expelling him, shall have the right to appeal to the Council, which upon a majority vote may permit him to become a member of an adjacent county society.

Section 7. In hearing appeals, the Council may admit oral or written evidence as in its judgment will best and most fairly present the facts, but in case of every appeal, both as a Board and as individual councilors in district and county work, effort at conciliation and compromise shall precede all such hearings.

Section 8. When a member in good standing in a component society moves to another county in the State, his name, upon request, shall be transferred without cost to the roster of the county society into whose jurisdiction he moves.

Section 9. A physician living in or near a county line may hold membership in that county most convenient for him to attend, on permission of the county in whose jurisdiction he resides.

Section 10. Each county society shall have general direction of the affairs of the profession in the county, and its influence shall be constantly exerted for bettering the scientific, moral and material conditions of every physician in the county, and systematic efforts shall be made by each member, and by the society as a whole, to increase the membership until it embraces every qualified physician in the county.

Section 11. Frequent meetings shall be encouraged, and the most attractive programs arranged that are possible. The younger members shall be especially encouraged to do postgraduate and original research work, and to give the society the first benefit of such labors. Official position and other references shall be unstintingly given to such members.

Section 12. At the time of the annual election of officers each component society shall elect a delegate or delegates to represent it in the House of Delegates of the Association in the proportion of one delegate to each twenty-five members or major fraction thereof. Provided, however, that each component society shall be entitled to at least one delegate regardless of the number of members it may have and the secretary of the society shall send a list of such delegates to the secretary of this Association on or before April 1 of each year.

Section 13. The Secretary of each county society shall keep a roster of its members and a list of non-affiliated registered physicians of the county, in which shall be shown the full name, address, college and date of graduation, date of license to practice in this State, and such other information as may be deemed necessary. He shall furnish an official report containing such information, upon blanks supplied him for the purpose, to the Secretary of this Association, on the first day of January of each year, or as soon thereafter as possible, and at the same time the dues accruing from the annual assessment are sent in. In keeping such roster the Secretary shall note any change in the personnel of the profession by death or by removal to or from the county, and in making his annual report he shall be certain to account for every physician who has lived in the county during the year.

Section 14. The secretary of each county society shall report to the Kentucky Medical Journal full minutes of each meeting and forward to it all scientific papers and discussions which the society shall consider worthy of publication.

Section 15. County societies may invite Dentists, Pharmacists, Funeral Directors, or other professional persons to become Associate Members of the County Society but such Associate Members shall not have any privileges or representations in the State Association.

Chapter XIII. Amendments

These By-Laws may be amended by any Annual Session by a two-thirds vote of all the delegates present at that session, after the amendment has been laid on the table for one day.

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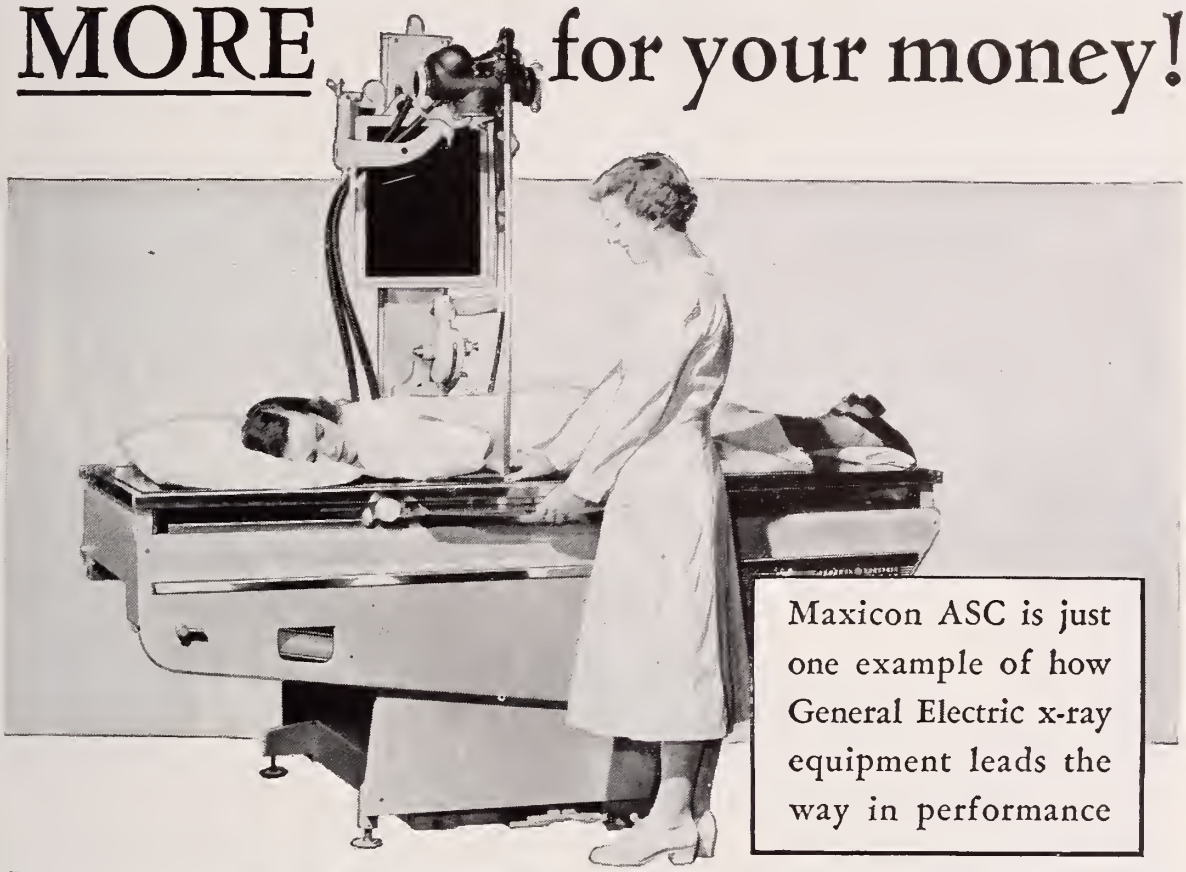
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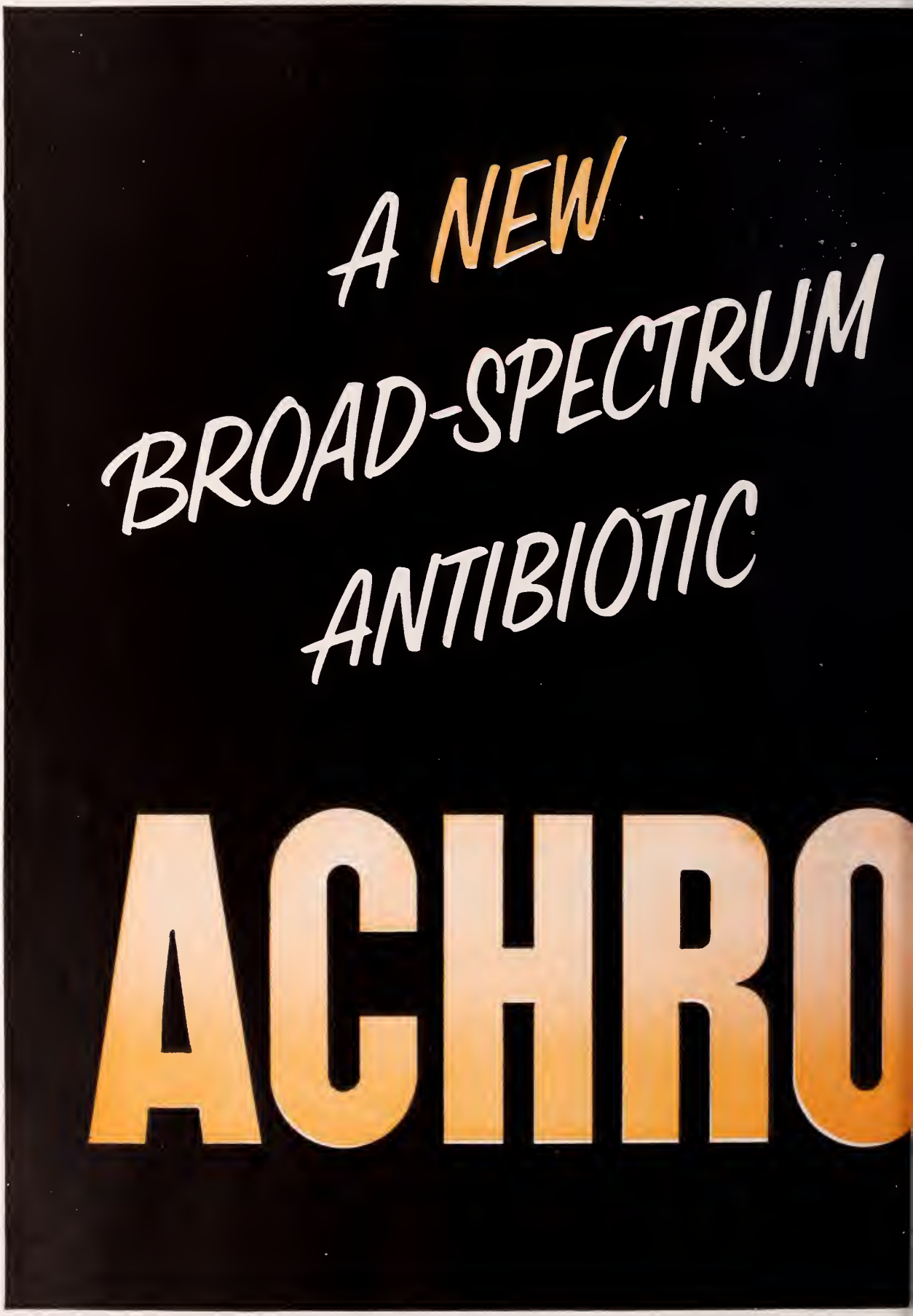
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1. Heller, E. M.: The Treatment of Essential Hypertension. *Canad. Med. Assn. Jour.*, 61:293, Sept., 1949.

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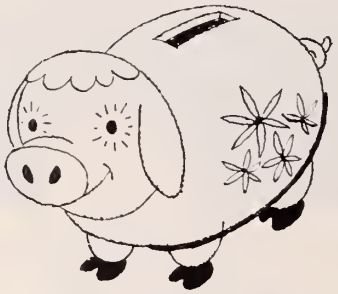
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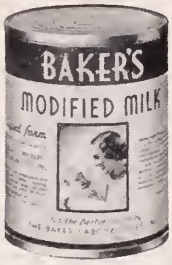
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1. Grigsby, M. E., et al., Antibiot. & Chemother., 10:1029, October, 1953.

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1. Sayer, R. J., et al.: Am. J. M. Sc. *221*:256 (Mar.) 1951.
2. Welch, H.: Ann. New York Acad. Sc. *53*:253 (Sept.) 1950.
3. Werner, C. A., et al.: Proc. Soc. Exper. Biol. & Med. *74*:261 (June) 1950.
4. Wolman, B., et al.: Brit. M. J. *1*:419 (Feb. 23) 1952.
5. Potterfield, T. G., et al.: J. Philadelphia Gen. Hosp. *2*:6 (Jan.) 1951.
6. King, E. Q., et al.: J. A. M. A. *143*:1 (May 6) 1950.

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VOL. 52 FEBRUARY, 1954 NO. 2

Contact Lenses: Current Concepts and Local Use

ARTHUR H. KEENEY, M.D.*
and
H. LYLE DUERSON, JR.*
Louisville

The purpose of this paper is to review the changes in contact lenses from the old, solution filled lenses to present tear filled lenses; to point out the indications, contraindications, problems and expectations of present lenses. An analysis of local use and statistics is added.

Historical

Contact lenses appear to date from 1801 when Sir Thomas Young made a crude water filled apparatus with a lens at the end of a glass tube one-fourth inch long. In 1823 Sir John Herchel of England described but did not apply the possibility of eliminating corneal astigmatism by placing on the eye a glass capsule containing gelatin. The first contact lens to be worn protractedly was prescribed by Theodore Sameish of Bonn in 1887. The lens was blown of glass by F. E. Mueller of Weisbaden and was worn as a protective shell for 21 years by a patient with complete lagophthalmos. Many experiments with blown glass lenses followed but practical fitting and accurate optics were seldom achieved. In 1911 Carl Zeiss produced a systematized series of ground glass lenses ("adhesion eye-lenses") but again did not achieve accurate fitting. In 1932 J. Dallos of London developed the technique of taking impression molds of the eye. His system was developed in America by T. E. Obrig of New York. In 1935 the Mueller-Welt firm of Stuttgart devised a series of glass lenses blown over preformed castings in an effort to eliminate molding and yet approach accurate scleral fit. Dallos in 1947 and the next year Obrig and Salvatori independently developed molded plastic lenses to be filled by tears and thus eliminate the old problem of artificial solutions. In the same year, plastic corneal lenses without a scleral rim (haptic) were introduced. This opens the current era of solutionless contact lenses.

Current Types of Contact Lenses

There are four general types of lenses in use today. A. The "conventional" contact lens (Fig. 1) is a molded plastic (methyl-methacrylate) lens, 19 to 24 mm. in diameter and requiring an artificial solution between the lens and cornea. This fluid factor and the blocking of atmos-

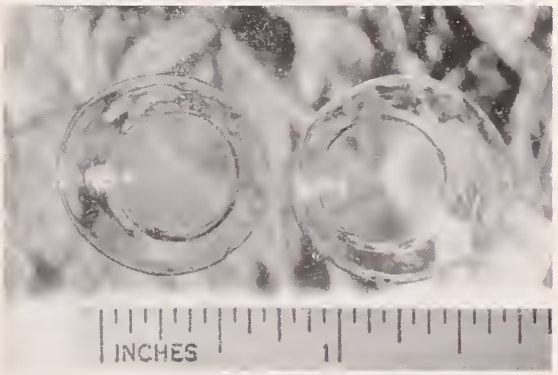


Fig. 1. Conventional contact lenses made entirely of plastic. The corneal portions are finished to optical specifications and the scleral rims are cast in molds made from the patient's eyes.

*From the Section on Ophthalmology of the University of Louisville School of Medicine.

Presented at the annual meeting of the Eye Section of the Kentucky State Medical Association, September 21, 1953.

pheric oxygen from the corneal epithelium are constant limitations to its use. This lens is now restricted primarily to keratoconus patients, in whom the irregular corneal surface makes capillary fitting hard to achieve. The subjective appearance of visual halos due to corneal edema usually limits wearing time between two and four hours, though it may be slightly longer in cold weather and shorter in hot weather. Of serviceable current lenses, this is the easiest to fit and with it patients report least reaction to external irritants such as smoke or dust.

B. Fenestrated or perforated lenses (Fig. 2) are tear-filled, lenses 21 to 26 mm. in diameter and having a hole to allow exchange of oxygen and tears. This is generally the most satisfactory type because the problems of artificial solutions and oxygen deprivation are eliminated. Dallos and Bier of England have pioneered with glass and plastic lenses of this type since the end of World War II. In their lenses a 1 mm. perforation is drilled at the interpalpebral limbus temporally. Salvatori and Obrig of New York have developed under the name "Lacrilens" a molded plastic, tear filled lens with the perforation about 3 mm. in diameter located beneath the lower lid. A grooved channel extends to the edge of the corneal portion. Wearing time is increased many fold because the cornea is bathed only in its usual fluids and oxygen exchange is maintained by a constantly moving air bubble in the limbal area.

C. The Mueller-Welt lenses (Fig. 3) are round, preformed plastic shells cast on a series of toric molds. Various manufacturers offer 12 to 36 combinations from which selection is made for trial and error fitting. The lenses are tear filled and oxygen exchange is made by the looseness of scleral fit rather than by fenestration. The lens is to be fitted as large and loose as possible. Cylinders and prisms cannot be incorporated because of the round shape and loose fit. The Mueller-Welt system has found particular favor with non-medical refractionists who may exchange optical and physiologic exactness for the elimination of molding and protracted periods of fitting.

D. Corneal lenses (Fig. 4) are small discs 10.5 to 12 mm. in diameter which are held in place by capillary approximation to the cornea. These were apparently introduced under the name "corneal caps" by Carl Zeiss in 1926, but proved to be impractical because of their weight. These early lenses were made of glass and would constantly gravitate below the cornea. In 1947 Mr. Kevin Touhy of Los Angeles devised a more practical corneal lens using the light weight optical plastics which had become available. Fitting may be done by trial and error selection from

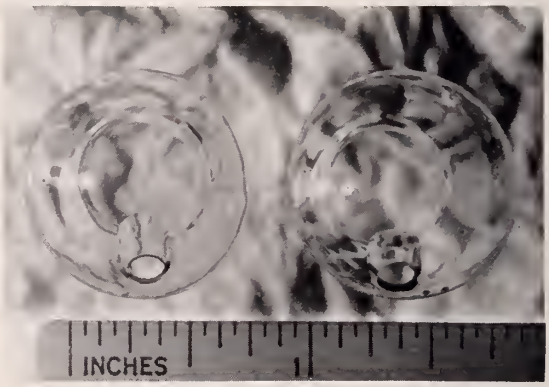


Fig. 2. Fenestrated "Lacrilenses" of all plastic construction.

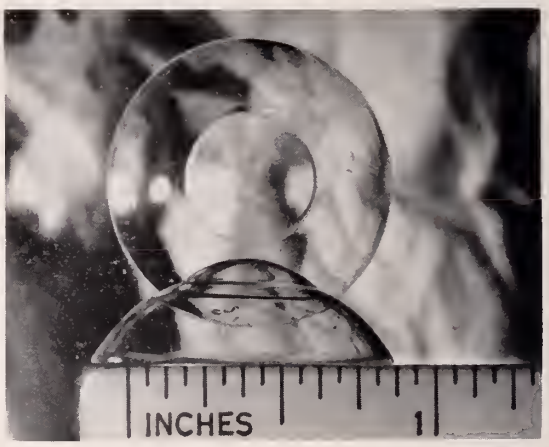


Fig. 3. Mueller-Welt type of pre-cast lenses.

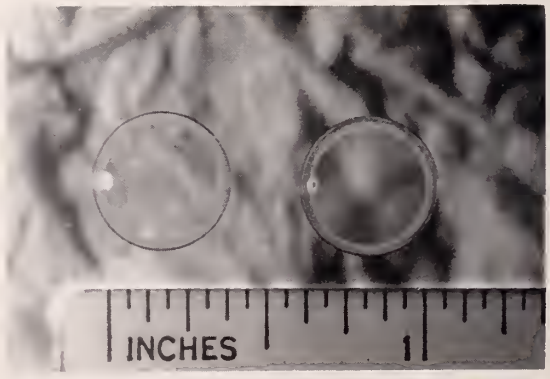


Fig. 4. Touhy type of plastic corneal lenses.

Footnote: Photographs by Department of Visual Education, University of Louisville School of Medicine.

series of 20 to 300 lenses or with the aid of keratometer readings. The lens should fit about 0.5 mm. inside the limbus except above where it extends about 1 mm. beyond the limbus. The lens must clear the corneal apex but move with blinking to afford exchange of the tear fluid between the lens and cornea. Neither cylinders nor prisms can be incorporated in their refractive strength and, right and left lenses are easily exchanged because of their essentially identical appearances. Patients report greater sensitivity to external irritants with this kind of lens than with the previously described types. Approximately 60% of patients medically sanctioned for corneal lenses cannot tolerate them on the basis of mechanical or psychological problems in fitting. The lenses may be extruded and present a constant threat of corneal abrasion. Cosmetically, however, they are the most desirable lenses and usually are completely invisible.

Indications

Contact lenses are indicated in higher corneal refractive errors and irregular astigmatism as seen in keratoconus, trauma, or following corneal transplantation. Keratoconus patients tolerate contact lenses particularly well due to the very real improvement in vision and a seemingly lower corneal sensitivity. In the presence of corneal scars visual improvement is often surprisingly good.

Monocular aphakia is an important indication particularly in younger patients following trauma. Differences in image size which pose such a problem when an aphakic eye is paired with a normal eye, are reduced to a point where single binocular vision is usually obtained, and tendencies to secondary lateral deviation are controlled. Best results are obtained when the lens is prescribed soon after surgery, allowing a minimal period of 6 to 8 weeks for the quieting of post-operative reaction[1].

Prosthetic contacts are used to improve the appearance of unsightly and shrunken globes. Individual molding is just as important here as in any contact lens and fitting must be equally meticulous. The front surface of the clear plastic lens is then painted to match the fellow eye. Motility is usually good and with proper centering of the iris, appearance is very satisfactory.

In neuroparalytic keratosis, scleral rim contacts may be used to avoid tarsorrhaphy[2]. In similar fashion, the British have found good use for the lenses in mustard gas keratitis victims from World War I[3].

About 80% of all contact lenses are fitted for cosmetic purposes. Within this group, the most successful patients seem to be myopic women between the ages of 15 and 35 years.

Swimmers and participants in vigorous athletics who are dependent upon a refractive correction are afforded considerable safety and protection by contact lenses.

Contraindications

Due to exploitation of the lenses many people who are not suitable candidates desire them. Technical contraindications are pre-presbyopia, frank presbyopia, minor refractive errors, high prismatic prescriptions, and in rare cases, allergy to plastic.

Medical contraindications are hay fever, vernal conjunctivitis, bullous keratosis, epithelial dystrophies, and any active or chronic infection of the lids, conjunctiva or anterior segment. Adherent leukoma and emotional instability either in the physician's office or technician's hands are relative contraindications.

Technical Procedures

Technical procedures require close harmony between the ophthalmologist and technician. The following outlines based on experience with several hundred fittings seem to yield best results for all concerned.

A. Molded Lenses. The ophthalmologist should complete his usual medical and refractive examination and then instill 0.5% pontocaine in the patient's eyes. The technician selects and inserts a trial contact lens on the basis of the refraction and corneal curvature. Manifest refraction is then repeated. Usually only spheres are required. The new refractive power and its vertex distance are noted. Any necessary prism strength is copied from the manifest determination as made before the trial contact refraction. The trial lens is removed and molds of the eyes are made by the technician. Cocaine must be avoided in these procedures because of its softening action on the epithelium. The molds are sent to the laboratory where the lenses

are made and returned in semi-finished form about 10 days later. Critical adjustments are then made in the technician's office. These usually require three or four visits of one to one and a half hours each, but at times fifteen or twenty visits are needed. When the lenses fit to the technician's satisfaction, the patient and technician return to the ophthalmologist for recheck of vision and any adjustment in refractive strength. If cylindrical power is needed, as is rarely the case, it is prescribed at this time. Final adjustments in the lenses are made and the patient instructed in their use. A program of wearing time is detailed and check-up visits scheduled.

B. Corneal Contacts. Corneal lenses are much simpler to fit. All the technician needs is the spectacle prescription, vertex distance, and a notation that corneal contacts are to be fitted. On the basis of corneal diameter and keratometer reading, the technician selects a lens from his trial set. This is inserted without anesthetic. Fit and movement are checked with fluorescein and a cobalt blue light to be certain of apical clearance. This procedure is repeated until a satisfactory fit is evident or unsuitability determined. If the trial disc can be worn with relative comfort for two hours in the technician's office, then lenses of prescription strength are ordered. When these are delivered, the patient is given minute instructions in their use. After two weeks of wear, the patient must return to the ophthalmologist for slit lamp and fluorescein check of the cornea. This should be repeated at three and six months intervals, and yearly thereafter.

Problems

One of the major initial difficulties in fitting is anxiety. Quite often the technician's first session is devoted principally to orientation. After the lenses have been inserted a few times initial apprehension usually subsides.

Of all the technical problems encountered in fitting tear filled lenses, the most vexing is the exact demand for capillary tolerances in fit. Corneal clearance must be kept between a minimum of 0.05 mm. and a maximum of 0.10 mm. This is easily upset by slightest inaccuracies in molding, small variances in manufacture or medical factors such as conjunctival edema or inflammation. This minute limit of tolerance is now the major impediment to wide acceptance of the tear filled lenses[4]. Average wearing time with "Lacrilenses" is now eight to ten hours though some patients report sixteen to 20 hours of day in and day out wear.

Personal tolerance varies somewhat unpredictably among patients. Those having experience with the old solution filled lenses adapt to tear filled lenses more rapidly than patients who have never worn contacts. The old problem of corneal veiling or clouding has been practically eliminated though some individuals develop slight clouding after eight to sixteen hours wear. Further research is needed to identify the presently obscure factors influencing individual tolerance.

Abrasions may easily be caused by corneal lenses. These are most likely to occur in the first several weeks of wear and result primarily from improper handling. Epithelial damage is sometimes caused by attrition during wear. If this does not appear during the first few months, it is unlikely to do so. There is little likelihood of abrasion with scleral rim lenses because they are designed to complete corneal clearance. On the whole, medical complications and serious insults to the eye are generally rare among all contact lens wearers[5].

Loss of lenses is primarily restricted to the corneal type which may extrude on sudden squeezing of the lids or extreme rotation.

An additional deterrent is mild photophobia which many patients report with all types of lenses. This can be reduced by the incorporation of a tint.

The long term picture for contact lenses has been considerably brightened by the development of tear-filled lenses. As fitting problems are reduced the price should fall and as more patients experience regular wear of their lenses the demand will naturally increase. In cyclic fashion such increasing usage will reduce fitting problems as wider experience is accumulated by both manufacturer and technician.

Advantages

Aside from obvious cosmetic considerations, contact lenses offer several advantages. In myopia the visual field is increased and the image size enlarged. Lenses do not have to be changed as often as spectacle corrections, because corneal astigmatism never enters into the refraction. In vigorous sports contacts offer far

more protection and convenience than do spectacles. Even in swimming and diving the scleral rim types can be worn to advantage.

In irregular astigmatism (developmental, keratoconic, traumatic, or post-operative) contact lenses offer the only optical solution. They also afford the most practical solution to problems of monocular aphakia.

Local Statistics

In eight years of fitting various types of lenses by one of us (H. L. D.) 424 units or sets have been dispensed in cooperation with practically all ophthalmologists of this area. Fifty-seven per cent have been fitted on women and 43% on men. The youngest patient in this series was 13 years of age and the oldest sixty-six. Twenty-nine patients have been fitted for keratoconus and these patients have been the most persevering and satisfied. Twenty-one of these are wearing their initial lenses, some of which have been in use for eight years.

Maximum errors corrected as determined from spectacle prescriptions have been 16 diopters of cylinder, 21 diopters of myopia and 16 diopters of hyperopia.

It is surprising that only six cases of monocular aphakia are present in this series. The results in this small group have been very satisfactory. One patient insists on a spare lens to be sure of having his contact at all times. The use of contact lenses in old cases of corneal scar or monocular aphakia has been less successful than in recent cases.

Summary

Contact lenses are of unique and specific value in many types of corneal irregularities. In addition they offer protective and cosmetic advantages. Unfortunately the progress in developing contact lenses has been marred by many innovations, wildcat schemes and exploitations which have confused the issues. Their course, however, has been continually forwarded by careful workers and has been particularly accelerated by the recent elimination of the artificial solution problem.

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Indications for Surgery in the Jaundiced Patient

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One of the most challenging problems to the physician and surgeon is the proper and expedient management of the jaundiced patient. How can the busy physician most effectively select those patients whose jaundice can be relieved only by surgical intervention? Some tend to rely on an extensive 'battery' of laboratory tests to make a differential diagnosis with little emphasis on the history and physical examination. On the other hand, some sway too far in the other direction and delay making any laboratory determinations while observing the early progress of the disease. Eventually liver damage may have progressed so far that confusing laboratory results are obtained. Both sides can be sobered by the fact that all too frequently there is no foolproof method of determining which jaundiced patient should be treated medically and which one will require surgery. Obviously the patient benefits more when the correct decision is made early, and indeed his life may be saved. One hundred consecutive jaundiced patients subjected to surgery were studied with reference to the accuracy of diagnosis and the common indications for surgery.

An Analysis of 100 Cases

A preoperative diagnosis of obstructive (posthepatic) jaundice was made in each

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case. These cases were culled from a large group of patients having hepato-cellular (hepatic) jaundice and a smaller group having hemolytic (prehepatic) jaundice. An analysis of the 100 cases showed that the correct preoperative diagnosis of surgical (obstructive or posthepatic) jaundice had been made in 89 patients. A benign cause was found in approximately one out of two cases, a malignant cause in one out of three cases, and a non-surgical (hepatocellular or medical) cause in approximately one out of ten cases. Since the latter group was not correctly differentiated from surgical jaundice an unnecessary exploration resulted. Such errors can be held to a minimum only if a clinical diagnosis based on a thorough history and physical examination is coordinated with the laboratory and X-ray findings.

A careful analysis of the type of pain and prodromal symptoms preceding the onset of jaundice will ferret out the majority of the surgical cases from the large group of jaundiced patients. Since common duct stones are responsible for approximately one half of all cases of obstructive jaundice requiring surgery, a past history of gallbladder disease is quite significant. Approximately 70 per cent of patients with common duct stone will give a history typical of biliary colic. However, it must be remembered that painless jaundice from common duct stone is not unusual (30 per cent). In our series of patients with common duct stones, 80 per cent gave a history of rather pronounced spontaneous nausea and vomiting accompanying each attack. This is quite compatible with distention experiments[6] on the gallbladder and common duct. A moderate amount of nausea and vomiting occurs with distention of the common duct, whereas it is rarely present with distention of the gallbladder. The reliability of this finding has recently been stressed by Strohl, et al[4]. Chills and fever which many times were rather mild occurred in three out of five patients, while a similar percentage of patients had a recurrent type of jaundice.

The Reliability of Jaundice

Mention might be made of the reliability of jaundice in establishing the diagnosis of common duct stone. Too frequently the surgeon may not seriously consider exploring the common duct for calculi unless the patient is jaundiced at the time of operation. In another series of 100 consecutive cases in whom a common duct stone was recovered, there was no history of jaundice in 35 per cent, a past history in 21 per cent and only 44 per cent were jaundiced at the time of surgery. The surgeon should remember to consider the possibility of common duct stone even in the absence of jaundice, lest the patient harbor a silent calculus which eventually will produce postoperative jaundice.

Two associated diseases, namely acute cholecystitis and acute pancreatitis, were not uncommonly found in the jaundiced patients having a common duct stone. Although the cystic duct is usually blocked by a calculus in acute cholecystitis, it should not be assumed that a stone did not escape into the common duct at some earlier time. In the series of 100 patients with common duct stone, the incidence of associated acute cholecystitis with common duct stone was one out of ten cases, and an elevated serum amylase level strongly supported the diagnosis of an associated acute pancreatitis with common duct stone in one out of seven cases. This points to the necessity of determining the serum amylase level if jaundice develops after a biliary attack. If elevated, surgery should be delayed until the acute pancreatitis has subsided.

Malignancy was responsible for the obstructive jaundice in one-third of the jaundiced cases operated upon. The history in these cases was not as helpful in a diagnostic way as in the patient with a common duct stone. The so-called typical case with a painless and progressive jaundice in an elderly thin male offers little difficulty in diagnosis. However, as others have shown, more than half of these patients do have bizarre upper abdominal pain which may be quite severe. Only one out of three patients with malignancy in this series had what might be termed a painless jaundice. Therefore, painless jaundice is not a consistent and reliable diagnostic sign of obstruction due to malignancy. More diagnostic significance should be attached to persistent jaundice of increasing intensity.

Weight Loss

A weight loss of more than 20 pounds was present in two out of three patients with malignant obstruction. However, in jaundiced patients of the benign group it was surprising how frequently the intolerance of food or fear of inducing colic by eating had produced a substantial loss of weight. The value of knowing the pa-

tient's weight loss is a more important consideration in forced nutritional replacement, whether for medical reasons or as a preoperative preparation, than as a diagnostic aid in differential diagnosis. Although itching has been heralded as strong evidence in favor of surgical or obstructive jaundice, we have found this symptom to be of little diagnostic significance.

The development of jaundice immediately following cholecystectomy strongly suggests injury to the common bile duct[1,2]. It is regrettable that a postoperative stricture of the common duct was found in seven patients in this series who had previously undergone gallbladder surgery elsewhere. Usually there have been technical difficulties from inadequate exposure or in controlling hemorrhage deep in the operative site. Regardless of the time interval during which jaundice develops in a patient who has had previous gallbladder surgery, the physician should make every effort to ascertain the details of the original procedure.

In addition to injury of the common bile duct, jaundice in the early postoperative period may be due to an overlooked common duct stone or hepatitis from transfusions. In the late postoperative period common duct stone is the most probable cause especially if the gallbladder was only drained by cholecystostomy. We have also observed several patients in whom calculi had reformed in a dilated retained cystic duct stump and eventually passed into the common duct. The necessity for a secondary operation to remove overlooked pathology is unfortunate in itself, because the patient in whom a stricture of the common duct has resulted is usually in a more serious condition than before the first operation, regardless of the severity of the initial symptoms. The biliary tract has always fascinated anyone attempting abdominal surgery, but nature has handicapped even the most experienced surgeon by providing more anatomical variations in the region of the cystic duct than anywhere else in the entire body.

Additional Historical Information

Other additional historical information which supports the diagnosis of medical rather than surgical jaundice is a recent history of blood or plasma transfusions, injections, drugs, or exposure to patients with infectious hepatitis. Occupational history is frequently important where organic solvents and vapors may be responsible for toxic hepatitis or acute yellow atrophy of the liver. A familial history of hemolytic anemia with or without gallstones is very important in the elimination of prehepatic jaundice. Knowledge of previous operations for carcinoma with the onset of an increasing jaundice should always make the physician suspicious of a metastasis obstructing the extrahepatic biliary tract.

Physical Examination

Although the physical examination of the jaundiced patient may be disappointing from a diagnostic point of view it is more likely to be contributory in surgical jaundice. A clinical impression can often be gained by observing the intensity of the jaundice. The intense greenish yellow of complete surgical jaundice from malignancy has been contrasted to the canary yellow of severe liver damage such as acute yellow atrophy of the liver.

Since the liver is usually enlarged and tender in the presence of jaundice of most types, it contributes little to the differential diagnosis unless distinct metastatic nodules can be palpated. Evidence of either primary or recurrent carcinoma in the gastrointestinal tract suggests a metastatic spread to the region of the hilum of the liver. In this series of 100 jaundiced cases three such patients were encountered. On the other hand an enlarged spleen increases the diagnostic possibilities considerably and serves as a danger signal to the surgeon. Congenital and acquired hemolytic anemia and cirrhosis of the liver must be considered in these cases and extensive hematologic investigation initiated. During the period of time that the 100 cases of obstructive jaundice were studied there were 78 cases of hemolytic anemia requiring splenectomy. Several of these patients had associated common duct stones of the bile pigment type.

The finding of a distended gallbladder in the presence of obstructive jaundice from carcinoma is of considerable importance and certainly a point commonly emphasized. In the presence of intense jaundice a distended, easily palpable gallbladder is indicative of surgical jaundice from carcinomatous obstruction of the lower end of the common duct. In our series a distended gallbladder was palpable in two thirds of the patients with carcinoma of the head of the pancreas. The

absence of a distended gallbladder in the presence of jaundice favors the diagnosis of a common duct stone since the chronically inflamed and scarred gallbladder, which is invariably associated with cholelithiasis, cannot distend in response to the common duct obstruction. And, lastly, an easily palpable, non-tender gallbladder in the absence of jaundice is indicative of a hydrops from a stone occluding the cystic duct. The principles of Courvoisier's Law are certainly worth remembering in the investigation of the jaundiced patient.

Only after a thorough history and physical examination have been summed up in a definite clinical impression should the results of any laboratory tests be evaluated. (Fig. 1) While blood analyses require extensive and complex laboratory facilities it should be the responsibility of the physician to personally examine the stool and urine. Gray stools imply an absence of bile or complete obstruction and if consistently so discolored, surgical intervention is strongly indicated. In the presence of a complete obstruction, bile does not reach the intestine to be converted to urobilinogen, and consequently, will be absent in the stool. Normally the urobilinogen is reabsorbed from the bowel and varying amounts are excreted in the urine. Obviously if it is absent in the intestine, there will be no urobilinogen excreted in the urine. The Ehrlich aldehyde test can easily be applied to a urine sample to determine the presence or absence of urobilinogen. When it is absent in repeated tests one may assume that the patient has an obstructive jaundice which requires surgical intervention. Unfortunately, except in complete obstruction, varying amounts of bile may reach the intestine and the above test requires, to be valid, a 24 hour estimation of the amount of urobilinogen excreted. If malignant obstruction of the common duct due to carcinoma in the region of the papilla of Vater is suspected, the stool should be examined for occult blood. Although the test for bile in the urine is simple, it is of no diagnostic significance unless absent in the presence of jaundice. Under these circumstances of acholuric jaundice a diagnosis of congenital or acquired hemolytic anemia should be suspicioned.

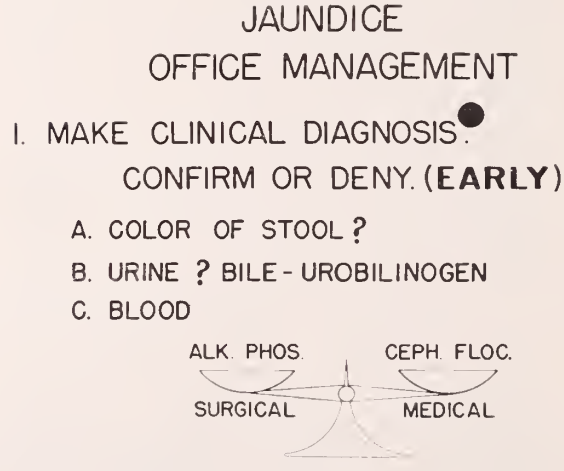


Fig. 1. Clinical as well as laboratory evidence should be balanced for or against surgery.

Liver Function Tests

From the large, so-called battery of liver function tests, the physician should select a few most likely to indicate a medical jaundice, a few to support a diagnosis of obstructive or surgical jaundice, and a measure of the degree of jaundice. If these tests are carried out when the patient is first seen, and repeated in seven to ten days, the chance of obtaining some help in differential diagnosis is improved. However, if the physician delays obtaining any liver function tests for several weeks, hoping that the jaundice will subside, he nullifies the diagnostic value of many of the laboratory findings which might support the diagnosis of surgical jaundice. Eventually, superimposed liver damage from the prolonged obstruction may become evident in the laboratory tests and result in mixed or non-diagnostic findings. In ordinary hospital practice the number of laboratory tests on a jaundiced patient will approximate two dozen. If we were held to a minimum of laboratory tests we would select the icterus index as a base line for the progress of jaundice, an alkaline phosphatase for evidence of extrahepatic obstruction, and the prothrombin time, cephalin flocculation and thymol turbidity to assess the amount of cellular liver damage.

These tests provided, to a surprising degree, the primary diagnostic support in the differentiation between medical and surgical jaundice. For example the cephalin flocculation and the thymol turbidity were elevated in over 80 per cent of the cases of medical jaundice mistakenly subjected to surgery. In contrast the cephalin flocculation showed a similar elevation in only 2.5 per cent of the cases of common

duct stone and in 13 per cent of the malignant obstructions. The thymol turbidity test was not as significant since there was an elevation to 40 per cent in benign jaundice and 33 per cent in malignant jaundice. The alkaline phosphatase test was elevated in 88 per cent of the malignant obstructions, in 48 per cent of the benign obstructions and in 44 per cent of the medical cases seen. The icterus index was consistently over 100 in 60 per cent of the malignant obstructions, in 10 per cent of the benign obstructions and in 20 per cent of the medical cases.

There are justifiable reasons for the variations shown in these 100 cases. The jaundice in approximately one third of the cases had existed longer than one month and during this period secondary liver damage was no doubt superimposed upon the obstruction. There was also evidence of intrahepatic obstruction from primary liver damage in one half of the non-surgical cases. These factors provide contradictory evidence and tend to re-emphasize the extreme importance of early laboratory evaluation followed by repeated checks for confirmation of a trend to either support or nullify the recommendation for surgery.

Like others we have a great deal of respect for the prothrombin level as an index of liver damage. A prothrombin time below 50 per cent of normal which does not respond to Vitamin K therapy is indicative of severe cellular liver damage. Rarely is a patient accepted for surgery of any type whose prothrombin time will not elevate well above 50 per cent in response to Vitamin K.

While reliance should be placed on a relatively few laboratory tests insofar as differential diagnosis is concerned, there are others which are quite helpful in evaluating the patient as a surgical risk. Although the total serum protein was low in one third of the cases the albumin-globulin ratio was altered in one fifth of the benign obstructions and in one half of the malignant and non-surgical cases. Of considerable importance was the elevation of amylase in 21 per cent of the cases of benign obstruction. It is surprising how frequently pancreatitis is encountered if the blood amylase levels are determined early and routinely. The van den Bergh test rarely influenced our clinical impression except in the cases of hemolytic jaundice where the indirect reaction is so consistently elevated. However, many clinicians prefer the van den Bergh to the icterus index because of its specificity in measuring serum bilirubin (not hemolysis and lipemia) and it serves as a more quantitative measure of jaundice. The percentage of cholesterol esters are said to be a rather important and reliable indication of liver function. Although they do not differentiate between medical and surgical jaundice a low percentage of cholesterol esters (below 50 per cent) is usually regarded as a danger signal and poor prognostic sign when operation is considered. A moderate anemia and lowered blood volume are usually present in all forms of jaundice which offer no specificity in terms of diagnosis.

X-ray Studies

Certainly no jaundiced patient should be subjected to surgery without a complete gastro-intestinal X-ray study regardless of how obvious the diagnosis may seem. The discovery of unsuspected malignancy, distortion of the duodenum from carcinoma of the head of the pancreas or papilla of Vater, and appearance of gallstones are all invaluable in establishing a diagnosis in the jaundiced patient. Although cholecystograms, for obvious reasons, are considered inaccurate in the presence of jaundice, we were surprised how often this test showed evidence of gallstones. In the presence of a mild or decreasing jaundice, a cholecystogram or an attempt at visualization of the common duct may be of value using new contrast media such as "telepeque." A flat plate of the abdomen may show gallstones and with a history of typical gallbladder disease help confirm a diagnosis of common duct stone. Evidence of air or barium in the biliary tree or gallbladder aids in the diagnosis of an internal biliary fistula. Postoperative jaundice with an external biliary fistula may be investigated by injection of the sinus tract with contrast media to determine patency of the common duct and site of obstruction.

Needle Biopsy

A needle biopsy of the liver is used in many clinics as an accurate and safe diagnostic method of making a differential diagnosis in cases of jaundice[5]. In experienced hands, it appears to be a very safe and reliable diagnostic procedure. Since we have observed massive intraperitoneal hemorrhages as well as bile peritonitis following this procedure, we

do not share the enthusiasm of some of our medical colleagues as to the safety of this procedure. Certainly it would not seem to be advisable in the presence of marked extrahepatic obstruction because of the danger of bile leakage into the peritoneal cavity. Nevertheless, it is usually valuable as an accessory tool in cases of jaundice of doubtful etiology.

We were especially interested in the eleven non-surgical cases that had unnecessary surgery since this group represents a mistaken preoperative diagnosis of obstructive or surgical jaundice. Although a failure in approximately one out of ten cases might be condoned, on the other hand surgery had nothing to offer these patients except an increased morbidity and possible mortality. The diagnosis established at the time of operation was as follows: hepatitis, 5; biliary cirrhosis, 3; cholangitis, 2; and diffuse involvement of the liver with Hodgkin's disease, 1. On the justifiable side as far as we were concerned was the fact that one half of these patients had gallstones by X-ray and there was laboratory evidence favoring obstructive jaundice in one half of the cases. A very careful analysis was made of all aspects of diagnosis and management in an effort to avoid such mistakes in the future.

Two factors did stand out which tended to condemn the indications for surgery. In the first place approximately 80 per cent of the eleven medical cases had high cephalin and thymol determinations clearly indicating severe liver damage. Furthermore, about one half of these patients had been operated upon too quickly (10 to 14 days) after the onset of jaundice without allowing sufficient time to re-evaluate the suggestive laboratory evidence. Actually one half of the patients in this group had obstructive jaundice of the intrahepatic type due to severe liver damage. Although the jaundice patient must not be "studied to death"[3] before operation, it is often desirable to delay surgery until the diagnosis of surgical jaundice is more certain. If the physician, after completing the history and physical examination, sums up his evidence as to the probable cause of jaundice, he should feel sufficiently secure in his impressions to resist changing his diagnosis except in instances of most convincing and sustained laboratory evidence. Further delay is not wasted time if the patient is energetically treated in preparation for possible operation.

The Primary Preoperative Goal

The improvement of nutrition should be the primary preoperative goal for the jaundiced patient. The wisdom of supplying calories and protein to the patient with liver disease has been clearly shown by Ravdin. However, there appears to be a general tendency to meet these caloric demands in a rather routine half-hearted manner by administering 10 per cent glucose intravenously for a few days preoperatively without paying close attention to the patient's oral intake. Metabolic studies in our clinic and elsewhere have shown that jaundiced patients lose one-third or more fat ingested. Fat is a rich source of calories and the loss should be held to a minimum. We have found it advantageous to force-feed some of these patients through a small polyethylene nasogastric tube. The fat absorption is improved by the addition of 1 cc. of Sorlate^{R} (Tween 80) to each quart of milk in the feeding mixture. If the patient has a biliary fistula, we have cannibalized bile from other postoperative patients and mixed it with milk given through a nasogastric tube.

Vitamin deficiencies were corrected by the administration of Vitamin K to insure a prothrombin level above 50 per cent of normal. Vitamin B Complex and one gram of Vitamin C were supplied daily. Prophylactic antibiotic therapy in the form of penicillin and streptomycin or aureomycin were given if there was evidence of sepsis. Such prophylaxis has some merit in protecting the liver should the blood supply be inadvertently injured, especially in difficult secondary operations.

In addition to oral and intravenous feeding any anemia or protein deficiency should be corrected. This is especially important as shown in our cases where two out of three had lost over twenty pounds in weight and well over one half of these jaundiced patients had an inadequate caloric intake. Routine blood counts and serum protein determinations showed only one out of four of these patients to have a blood volume and tissue protein deficit greater than 20 per cent. This provided a false sense of security as shown by the more accurate blood volume measurements. Utilizing radioactive iodinated human serum albumin in small dosage, it was possible to make serial blood volume determinations in these jaundiced patients with a much greater degree of accuracy

than hitherto possible with Evans blue dye. These results showed that 75 per cent of the cases, rather than 25 per cent, were in deficit over 20 per cent of their calculated normal. The deeply jaundiced patient usually requires two or three transfusions to restore his blood volume to a normal range. These deficits were met by repeated blood transfusions, administration of human albumin, protolysates, and 10 per cent glucose. We are convinced of the value of repeated blood volume determinations in the preoperative preparation of those poor risk surgical patients. If this laboratory method is not available it would seem desirable to give at least two or three transfusions in the severely jaundiced patient before operation.

Re-evaluation of the Patient

It is always advisable to re-evaluate the jaundiced patient before setting a definite time for operation. Surgery should be delayed and actually is contraindicated if reconsideration of the history and physical examination is indecisive for surgical jaundice due to common duct stones, obstructing tumors of the extrahepatic biliary tree or postoperative stricture. A history of recent transfusions or injections, exposure to drugs or poisons, or the presence of a palpable spleen should alert the surgeon to a medical cause for the patient's jaundice and require further investigation.

Likewise, certain laboratory tests stand out as danger signals which must not be ignored. If the cephalin and thymol tests are elevated or increased, the presence of intrahepatic cellular disease rather than surgical jaundice should be considered. A normal alkaline phosphatase indicates absence of surgical jaundice and is a contraindication to surgery. Reversal of the albumin-globulin ratio which is not corrected by adequate preoperative preparation should also be a reason for delaying operation. Finally, low cholesterol esters, (50 per cent or below) and the failure of the prothrombin time to rise well above 50 per cent in response to Vitamin K therapy are highly suggestive of advanced cellular liver damage. As previously stated, we have tended to refuse surgery to any patient unless the prothrombin time can be adequately elevated above 50 per cent. Surgical intervention can be considered when the history and physical examinations are compatible with obstructive jaundice, persistent jaundice lasts longer than three weeks despite adequate medical therapy, and only if the laboratory data favors obstruction. In general, surgery is delayed until a sufficient caloric and protein intake have been provided, the blood volume restored to normal values, and the prothrombin time elevated above 50 per cent.

Principles at Surgery

The principles at surgery in the jaundiced patient are directed at relief of the jaundice, prevention of postoperative jaundice, and establishment of the type and extent of liver damage.

It is very important to remove all common duct stones and insure the patency of the papilla of Vater. Although all obstructing neoplasms cannot be removed many may be bypassed so that the uncomfortable symptoms from intense jaundice and progressive liver damage are minimized. Prevention of postoperative jaundice can be attained by careful complete surgery and avoidance of injury to the common bile duct. Minimizing the use of plasma before and during the operative procedure will help decrease incidence of postoperative jaundice due to hepatitis. In cases in which definite pathologic diagnosis cannot be established at surgery, it is imperative to obtain a liver biopsy to aid in the diagnosis and prognosis of the complicated case.

To insure a low morbidity and mortality rate the jaundiced patient requires more work and study in all aspects of diagnosis and treatment than almost any other type of patient. If a well formulated plan is followed it is possible to select with a high degree of accuracy those jaundiced patients most likely to be relieved by surgery. Very gratifying results are obtained if a common duct stone is recovered. The repair of strictures, while not as uniformly successful, is always worthwhile regardless of how many previous repairs have been attempted.

Although relatively few malignancies producing obstructive jaundice can be surgically extirpated, the individual patient should be given this opportunity. In our series exploration was definitely worthwhile in two out of three of the 34 patients having obstructive jaundice from carcinoma. All were relieved of their jaundice which was certainly worthwhile as far as the comfort of the patient was concerned. In three cases the head of the pancreas was resected without a mortality. One out of three patients was less fortu-

nate in that the malignancy was so far advanced that nothing more than proof of the diagnosis was established.

The patient with obstructive jaundice, regardless of age, should be given the benefit of surgical exploration. In a great majority of instances the benign cause can be removed and even in the presence of inoperable malignancy, relief of the jaundice, so greatly appreciated by the patient, can be effected.

Conclusions

1. A clinical impression based on a thorough history and physical examination of the jaundiced patient should be made before evaluating the laboratory evidence.
2. Laboratory tests, if made early and repeatedly, provide valuable support in differentiating between medical and surgical jaundice.
1. Gray stool, decreased or absent urobilinogen in the urine and elevated blood alkaline phosphatase support the diagnosis of surgical jaundice.
4. Elevated cephalin flocculation and thymol turbidity, poor prothrombin response to Vitamin K, and low cholesterol esters support the diagnosis of medical jaundice and are reasons for delaying surgery.
5. Nutritional replacement by forced feeding with the addition of bile or Tween 80 and accurate replacement of blood volume deficiencies decrease the surgical risk.
6. The preoperative diagnosis of obstructive jaundice was confirmed at operation in 89 out of 100 consecutive cases.
7. Neither age nor etiology is a contraindication to surgery in extrahepatic jaundice since the cause can be removed or palliation provided in a high percentage of cases.

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Myeloma of the Sternum

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Tumors of the sternum most frequently include chondromas or chondromyxomas, multiple myelomas, Hodgkin's granulomas, metastatic carcinomas or osteochondromas.

Chondromas or chondromyxomas are typically benign lesions occurring frequently in the small bones of the hands and feet of young people 20 to 30 years of age. They occasionally occur in the sternum or ribs where they may attain considerable size. In this location they are more prone to malignant change and to recurrence after primary operation. Pain and swelling are usually not prominent symptoms. A sudden increase in size indicating malignant degeneration is far more common in sternal or rib lesions and recurrence is more likely in these sites.

Hodgkin's granuloma affects bone more frequently than is often realized. Involvement of the sternum is second only to the vertebrae. Sternal lesions close to involved mediastinal nodes usually show marked periosteal reaction with cortical destruction.

Metastatic lesions to the sternum usually are secondary to breast carcinoma. In a series of 100 cases of mammary cancer with bony metastasis, the sternum was involved in 4%[1].

In rare instances, osteo-chondroma or exostosis occur in the sternum. These benign symptomatic lesions are found in young people.

Although solitary foci of myeloma have been reported[1,2,3,4,5], later study on most of these cases has usually revealed a mul-

tiple generalized destructive process. We feel the following case is illustrative of this fact and warrants presentation.

Case Report

C. B. (169-938), a 42-year-old white female, para XII, gravid XI, was in good general health until November 1951. Her maternal grandmother had died of carcinoma of the womb, her mother's sister died of carcinoma of the liver. She had had no serious illness but had undergone a bilateral tubal ligation in July 1951.

She was admitted to Good Samaritan Hospital on Oct. 24, 1952, because of a painless mass on the anterior chest wall and a weight loss of six pounds during the previous six months. In November, 1951, she was first conscious of a small painless swelling over the lower border of the sternum. This had gradually increased in size over a 12 months period; however, during the last three months it had doubled. There was no history of pain, cough, hemoptysis, pleurisy, dyspnea, or cyanosis.

Physical findings on admission revealed a well-nourished, white female in no acute distress, with a blood pressure of 122/70, pulse 78, temperature 98.6 F., and respirations of 22. A 6 x 8 cm. firm, fixed, non-expansile, non-tender tumor was present over the region of the manubrium sterni from which it appeared to originate. The overlying skin was intact and showed no edema, erythema, or pigmentation. There was no lymphadenopathy. The heart, lungs, and breasts showed no abnormality.

The pupils were equal and reacted to light and accommodation. The mucous membranes appeared pink. The cranial nerves and peripheral reflexes were intact. There was no abdominal mass, tenderness or rigidity; a well healed suprapubic midline incision was present. Rectal, pelvic, and extremity examinations were essentially negative.

Laboratory findings were: red blood count 3,900,000, hemoglobin 11 Gm., white blood count 10,600, neutrophils 75 per cent, lymphocytes 25 per cent, stabs 6. Red blood cells showed no marked variation. Serology reported Kahn as negative. Urinalysis revealed 4 to 6 white cells per high power field, but was otherwise negative. Total blood protein was 6.59 gm.%; albumin 4.30 gm.%, globulin 2.29gm.%. A/G ratio was 1.87/1. Urinalysis for Bence Jones protein was negative on two occasions.

Roentgenologic Examination. The sternoclavicular area by anterio-posterior, lateral and oblique views revealed the manubrium to be completely replaced by a large irregular, expanding lesion showing a reticular network pattern with areas of radiolucency surrounded by thin strands of bony trabeculations. There was one area somewhat posteriorly and to the left of the mass which showed a fairly homogeneous density and had a more solid appearance than the remaining portion of the tumefaction. The radiographic appearance was not unlike the soap-bubble structure characteristic of a solitary myeloma, but resembling osteoclastoma.

A 6 ft. P. A. film of the chest, examination of the skull by rt. lateral and occipital views, and anterio-posterior views of the pelvis including both hip joints failed to reveal any evidence of bone destruction or production. There was no evidence of osteoporosis. Retrograde pyelography showed normal filling of the renal pelves and calyces on both sides.

Course in Hospital. The patient was given 500 cc. of blood by transfusion and on 10/27/52, under general anesthesia, a biopsy of the tumor mass was undertaken through a curved transverse incision, the lateral angles of which extended to the sterno-clavicular joint. Following reflection of the pectoral muscles, the manubrium sterni appeared to be distended and enlarged from within. Its anterior surface was replaced by irregular spicules of bone between which yellow-brown, highly vascular, semi-necrotic tissue seemed to expand. The body of the sternum was not involved.

Microscopic Findings. The tumor was highly cellular with a very small amount of delicate vascular stroma. The cells were somewhat variable in size and shape, varying from ovoids to irregular polyhedrals with scattered multi-nucleated giant cells evident. The nuclei were unusually small and dark staining. These findings were reviewed by three pathologists and felt to be representative of a myeloma of the sternum. The finding was confirmed by the Army Institute of Pathology, Washington, D. C.

Subsequent Course. Roentgen therapy was commenced November 30, 1952; however, patient failed to return following the first treatment.

She went to another city and received a course of X-ray therapy over the sternal region. On 6/2/53, she was again contacted and returned for follow-up. Her weight and general well-being were unchanged. The sternal lesion had not changed in size. Skeletal survey was essentially negative except for the previously noted sternal lesion which showed no essential roentgenographic change in appearance. It was thought advisable to obtain bone marrow biopsies from other red marrow sites. These were taken from the body of the sternum and right iliac crest. Both sites had normal roentgenographic appearance.

The pathology report was as follows:

Gross: The specimen consisted of bone marrow aspirations from (1) a tumor of the manubrium sternum (2) the body of the sternum between the second and third ribs (3) the right iliac crest. On aspirating from the tumor mass in the manubrium sternum, the material obtained appeared to be necrotic and degenerating tissue. Volumetric studies showed:

Plasma	61 cu. mm.
ME	.75 cu. mm.
RBC	38.25 cu. mm.

Aspirations from the body of the sternum and from the right iliac crest yielded normal appearing bone marrow containing many particles. Volumetric studies on the material from the sternum showed:

Fat	.5 cu. mm.
Plasma	55 cu. mm.
ME	3 cu. mm.
RBC	41.5 cu. mm.

Volumetric studies on material from the right iliac crest showed:

Fat	1 cu. mm.
Plasma	60 cu. mm.
ME	3 cu. mm.
RBC	36 cu. mm.

Smears of all areas were made.

Histopathology: Examination from material aspirated from the tumor mass showed mostly red blood cells and occasional degenerating cells which were unrecognizable. Visible tumor tissue was not present in the aspirated material from the area which had been extensively treated with X-ray.

Multiple smears from the body of the sternum and from the right iliac crest appeared essentially the same. Throughout the smears there were numerous very atypical plasma cells. Some contained two and three nuclei. Many showed quite voluminous cytoplasm which stained rather darkly. There was considerable variation in size and shape, some being small and rather mature, while others were tremendous plasma cells with a large amount of feathery dark blue staining cytoplasm. The nuclei of these cells appeared very immature. Red blood cell production appeared rather markedly depressed in both areas.

Platelets: Platelets were fairly numerous and occasional megakaryocytes were seen. The granulocytic series showed presence of all elements. Their numbers were somewhat suppressed.



Fig. 1. Lateral view showing complete destruction of the manubrium.



Fig. 2. Oblique view reveals roentgenographic pattern similar to Osteoclastoma.

Diagnosis: Rather undifferentiated myeloma found in smears and sections of the sternum and right iliac crest.

Discussion

Multiple myeloma or plasma cell myeloma is a disease of the red marrow occuring in later life. According to Gesheckter and Copeland, 80% of the cases occur between 40 and 70 years of age with a peak incidence at 55 years[1]. Various etiological theories including trauma, infection and primary disturbances in plasma protein have been considered but not confirmed. The outstanding clinical features include pain and tumor formation. The pain initially may progress from vague discomfort to rheumatic pain to severe agonizing constant pain terminally. Since the vertebrae are most frequently involved, pain is usually lumbo sacral in location (70%) or sternal and costal 20%. The tumors usually appear as multiple swellings of the ribs, spine, or sternum.

Roentgen findings in myeloma are not specific. In fact there is an increase in appreciation of the difficulties in establishing the diagnosis of myeloma by the appearance of the osseous structures. Hieser and Schwartzman classified the findings in sixty-two cases as follows: 1) Normal skeletal findings were found in 13%, 2) Non specific osteo-porosis not distinguishable from that found in hyperparathyroidism or menopausal disease, 3) Sharply punched out areas of destruction 13%, 4) Poorly circumscribed bone destruction simulating metastasis from lung, thyroid, or kidney, and 5) Severe bone destruction with complete replacement of bone with only a thin cortical shell remaining or else radiolucent areas surrounded by trabeculae giving a reticulated or honeycomb appearance[6]. Our case is similar to the latter pattern.

In recent literature, there is controversy as to the existence of solitary lesions. Gesheckter feels that "although solitary foci of multiple myeloma have been reported, exceptions are so rare that one is justified in stating that myeloma is always multiple in distribution."[1]

He reported a case in which the upper femur alone was the seat of plasmocytic myeloma. "Five years later, the patient had involvement of the lumbar vertebrae and succumbed to the disease. In another case referred to by the authors, the only demonstrable site involved the wing of the ilium. While no other lesions were found at autopsy, it is entirely possible that myeloma cells could have been demonstrated in the marrow had smears been taken. Paul and Pohle collected 45 cases of solitary myeloma from the literature in 1942. While a single focus of bone involvement was the outstanding feature of these cases, sternal marrow punctures in such instances revealed that the myeloma cells were more widely spread in the red marrow."[1]

Some authors classify solitary myelomas into two groups. First, those in which a solitary lesion is merely the first manifestation of a multicentric process and second, those in which the lesion is a truly localized process[2,3]. Years of observation are necessary to rule out additional foci[4]. Initially, we felt that our case represented a solitary lesion; however, follow-up marrow studies proved it to be the early manifestation of a generalized process.

Therapy

Various forms of therapy have been used. The prognosis is uniformly fatal. Average longevity is about three years although some cases have been reported surviving as long as 7 years[1].

Types of therapy include X-ray, urethane, radioactive phosphorous, stilbamadine, and nitrogen mustard. Lindengren et al.[8] felt that best palliative results were attained with radioactive phosphorus. Propp et al.[9] obtained fair results with stilbamadine. It is generally agreed that solitary lesions seem to be more radio sensitive than those multiple lesions discernable by X-ray after the process has become disseminated.

Summary

A case has been reported which initially appeared as a painless swelling of the sternum. Biopsy revealed a myeloma which on marrow studies six months later proved to be a multicentric process. All solitary sternal lesions should be biopsied. Marrow studies from other red marrow sites are of diagnostic value.

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Indications and Contraindications for Tonsillectomy

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This paper probably should have been entitled "The Tonsil and Adenoid Problem."

In early medical reports the tonsils are rarely mentioned; however, Celsus in 25 A. D. did clearly describe the enucleation operation. He advised that "indurated and inflamed tonsils should be scratched and torn out by the fingers, but if this fails one must seize them with a hook and cut them out with a knife, then wash the raw place with vinegar and smear the wound with some drug by which bleeding is stopped."

In reviewing medical literature it is apparent that during the 17th and 18th centuries a new interest was shown in the welfare of the child; however, there is no mention of tonsils and adenoids in the medical accounts of the period. The study of clinical pathology under the leadership of John Hunter aroused some interest in the pathology of the tonsils, and in 1828 Physick invented the tonsillotome because of the demand for a better way to remove the hypertrophied tonsil. A little later, in 1855, Meyer of Copenhagen pointed out the harmful influence of the adenoids on the hearing and growth of the child. It was still later, about 1885, that clinicians became concerned about the functions of the tonsils and the proper treatment of their diseased conditions.

Respect for normal tissue and fear of hemorrhage restrained physicians from removing tonsils as a general practice during that era. Gradually more attention was being paid to enlarged tonsils, and in addition to surgical removal various medical measures were devised to diminish the size of the tonsils. The most notable one was the use of galvanocautery.

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During the last two decades of the 19th century the conservative attitude gave way to one of strong indictment of tonsils as a serious menace to the child. The theory of infection of the tonsils was accepted and their partial removal was no longer satisfactory to surgeons. The modern era of tonsil treatment was born and has not changed greatly to the present day.

There is still debate in medical circles regarding the advisability of tonsillar removal. Both extremes are represented. There are those who firmly believe the tonsils should never be removed and, I am quite sure, there are those who over incriminate them and remove them unnecessarily.

Normal Function of Tonsils

Let's consider briefly what is known about the normal function of the tonsils and associated lymphoid tissue of Waldeyer's ring.

There are some facts which make it probable that the lymphoid tissue surrounding the entrance of the upper air passages is important in the defense of the respiratory and alimentary tracts against invasion by pathogenic microorganisms. There are other facts which indicate that this defensive mechanism is lost after puberty when the tonsils and adenoids usually become atrophied.

The maximum development of the tonsil and adenoid tissue coincides with the period in childhood of greatest rate of body growth and greatest danger from infectious diseases. This relationship of maximum lymphoid development to growth rate is also noted in other animals.

The evidence that the tonsils serve an important function is not definitely proven and is largely presumptive. However, it is reasonable to assume that these lymphoid tissues are purposeful because of the following reasons:

1. The maximum development of the tonsil coincides with the period in childhood of greatest body growth, intimating that the defensive mechanism of the tonsil and associated lymphoid tissue is present during a period of life when infectious diseases are most dangerous. The atrophy which occurs in later childhood and adult life does not occur until immunity has been largely established.
2. The location of this lymphoid tissue at the entrance of the upper air and food passages, through which pass all the food and air for the body, is in itself indicative.
3. The removal of this lymphoid tissue before the age of 5 to 6 years leads to the development of a compensatory hypertrophy of the "nonremovable" lymphoid tissue in the adjacent areas. This hypertrophy is most extensive on the posterior pharyngeal wall and in the lingual tonsil region.
4. The tonsillar and adenoid structures being lymphoid tissue can be expected to function in a manner similar to all lymphoid tissue in the body in that they offer some measure of protection against the invasion of microorganisms. The sharing of this function would seem to be their most obvious purpose.
5. It is a widely accepted and statistically supported view that early removal of tonsils, i.e. age of 2 to 4 years, leads to a greater incidence of acute laryngitis, bronchitis and even pneumonia.
6. It is biologically significant that all mammals have tonsils and that when born and raised under sterile conditions in the laboratory, there is a lack of lymphoid tissue in their bodies, but when given dead bacterial vaccines the lymphoid tissue will develop. There is also an absence of germinal centers in the lymphoid tissue of the new-born suggesting a state of immaturity or unreadiness for the function of antibody production.
7. There is significant evidence that lymphocytes aid in the formation of antibodies. It has been shown that lymphocytes invade the crypts of tonsils, take up bacteria by phagocytosis and return to the lymph nodes where they are destroyed, thus contributing to the immunization process in man's constant fight against infection.
8. Experiments with cortisone have shown that lymphocytes release antibodies and the rate of this release in lymphoid structures can be accelerated within a few hours by increased adrenal cortical secretion.

In view of these findings there is little doubt regarding the important role played by lymphoid tissue in producing immunity and in combating infection.

General Nature of the Problem

The tonsil "problem" today consists of deciding when the tonsils should and should not be removed. In many instances this calls for one's best judgment. In obvious cases of hypertrophy and infection the clinical signs are sufficient to leave no doubt about the advisability of their removal. However, in many of the patients, particularly children, subjected to this treatment, the clinical evidence has not been carefully considered and the reasons for removal are not too clear. All of us have seen patients who were not benefited by the procedure, in fact, some patients insist they were made worse.

Since no laboratory test is available to determine whether the tonsils are beneficial or harmful to the patient, the clinician's decision must rest on his own experience, on his evaluation of all the factors and the prevailing opinion of other recognized observers. The individual examination, based on impressions gathered from experience, is after all the final determinant in a clinical matter in which scientific tests and statistical analysis are not applicable.

In discussing the indications for tonsillectomy I include adenoidectomy as part of the procedure, because in my experience and that of other observers in the field the simultaneous performance of the two operations is preferable. However, in children younger than 4 years, adenoidectomy alone may be advisable; and in adults tonsillectomy alone is frequently performed since the adenoids usually disappear after puberty. If hypertrophied adenoid tissue is present in the adult having tonsillectomy, this structure is also removed.

Indications for Tonsillectomy

We shall now consider the indications for tonsillectomy keeping in mind at all times that a healthy tonsil does have one or more functions and that an infected tonsil can lose its helpful function and

actually produce both local and systemic harmful effects.

Indications for removal:

1. Repeated attacks of tonsillitis.

   The history of repeated attacks of tonsillitis, regardless of the organism present, has always been a reliable indication for tonsillectomy. These recurrent attacks are indicative of an irreversible relationship between the organism and the host, resulting in a permanently infected focus in the tonsil. Usually after tonsillectomy the patient will experience relief from such attacks. However, as you are all aware "sore throat" may occur after tonsillectomy even in patients in whom there is a minimum of remaining lymphoid tissue in adjacent areas.

2. Chronic tonsillitis—(a relative term). We grant that all tonsils contain infection but the clinical term "chronic tonsillitis" means more than that. It is used for want of a better term to imply that the infection present is severe enough to be considered detrimental to the patient. It has been the experience of those who have carefully observed the tonsil problem that persistent enlargement or tenderness of the lymph node at the angle of the jaw or cervical adenopathy in adjacent nodes is indicative of chronic tonsillitis. Chronic soreness and discomfort in the tonsillar region are frequently associated with the adenitis. Such tonsils may or may not be hypertrophied. It is not uncommon to find that these lymph nodes have disappeared a few weeks after tonsillectomy and the patient volunteers the information that his general health has definitely improved.

3. Hypertrophy of the tonsils or adenoid.

   It is the opinion of most observers that such hypertrophy in the child or adult is due to bacterial or viral infection.

   In my opinion viral infections are the chief cause of the hypertrophy and hyperplasia within the tonsil. This hypertrophy causes the tonsil to project from the fossa so that even the superior pole is often uncovered by the anterior pillar. Such tonsils produce detrimental effects not only because of the retention and absorption of infection but also because of the mechanical obstruction. Proper nasal respiration is interfered with resulting in deformities of the nose, palate and dental arches. The sinuses may be infected due to the poor nasal ventilation and drainage. Purulent nasal discharge is a fairly common finding in children with adenoid hypertrophy.

4. Loss of hearing of the conductive type with or without associated middle ear infection.

   This indication is more frequently seen in children but may be present in adults. The eustachian tube may be obstructed by lymphoid tissue producing hearing impairment. Transudate and exudate may be present in the middle ear, producing hearing loss. Signs of infection such as hyperemia of the drum or bulging are not always present. The more fulminating type of infection will produce pain in the ear or a spontaneous perforation with otorrhea. Since the advent of antibiotics we have seen an ever increasing number of "masked" cases. The fluid in the middle ear is sterile and the patient has no pain but hearing is definitely impaired. This symptom is unrecognized over prolonged periods and permanent hearing damage ensues.

   Removal of tonsils and adenoids will usually alleviate the condition in children but these procedures are less frequently successful in adults. It is sometimes necessary to use irradiation to the residual lymphoid tissue in the nasopharynx. I have found the methods advocated by Crowe extremely practical and satisfactory. However, one can use external irradiation if desired under the supervision of a radiologist.

5. Intratonsillar and peritonsillar abscess.

   The intratonsillar abscesses usually occur in the superior pole where the crypts slant downward and are covered by a fold of the pillar and supratonsillar plica. It is in this same area that the infection frequently extends through the capsule of the tonsil forming a peritonsillar abscess (quinsy). Here again removal of the tonsils affords relief from infection and prevents its recurrence.

6. Foci of infection.
   Here we will find more variance of opinion regarding the removal of tonsils. In infectious diseases, such as inflammatory rheumatism, myositis and the ocular infections, the clinician may be convinced there is an underlying infection, but can the tonsils be definitely established as the source of the infection? Certainly not. Nor can it be definitely established that they are not the source of infection. Therefore, extreme caution and careful judgment are mandatory before their removal is advised.
7. Recurring attacks of Vincent's tonsillitis.
   Such attacks are always indicative of chronic tonsillitis as the fusospirochetal organisms are incapable of initiating disease in normal tissues. A large percentage of tonsils harbor these microorganisms but only when ulceration or pseudo-membrane formation occurs is their presence thought to be significant.
8. Diphtheritic tonsillitis.
   Diphtheritic tonsillitis is rarely seen today. In carriers, removal of the tonsils is indicated after the acute infection has subsided.

Importance of Proper Caution

Tonsillectomy is not a minor operation and should never be undertaken by any physician unless he is thoroughly familiar with the indications for operation, the precautions necessary to safeguard the patient against catastrophe on the operating table, and, of course, the surgical technic.

The examination of every patient should consist of a careful history, a thorough physical examination, and laboratory studies including blood cell count, particularly hemoglobin content, bleeding and clotting time, and urinalysis. The results of the laboratory studies are important but the history and physical examination are of equal importance.

There is no excuse for doing a tonsillectomy on a child and then discovering one or more days later that the patient has thrombocytopenic purpura and associated severe tonsillar hemorrhage or to discover the patient has an aortic stenosis or chronic nephritis.

The problem of cardiac arrest is discussed too casually in my opinion. As you know it can happen during tonsillectomy, but why? The chief reason is a prolonged hypoxia which develops during the induction of the anesthetic or during the operation. The surgeon may be chiefly at fault because of his operative technic; he may interfere with the airway in obtaining proper exposure, or permit blood to enter the tracheobronchial tree, or perform a long and clumsy operation, all of which contribute to this catastrophe. There is a distinct hazard in conducting a teaching program where residents are learning the procedure. I believe we owe it to our patients to stay in the operating room when residents are performing tonsillectomies and adenoidectomies under general anesthesia. Only one cardiac arrest in a resident's experience in learning these procedures is too high a price in my estimation. The more experienced surgeon can usually anticipate disaster before it develops. Beginners many times have not learned the great virtue of cautiousness.

Contraindications to Tonsillectomy

The contraindications to tonsillectomy are again relative and not absolute.

1. Tonsils should not be removed for bizarre complaints with the "hope" of improvement (e.g. colds, indigestion, weight loss). Rarely will the patient be relieved.
2. The patient with a chronic anxiety state or other neurosis should not be subjected to the psychic trauma of the discomforts of surgery.
3. Patients should not be operated on during an acute infection. There is general agreement that this is a dangerous procedure because of the possibility of added local or systemic infection, or extension of the respiratory infection either due to the anesthetic or the operation itself. These patients are also difficult to manage during the induction of anesthesia. The inflamed and sensitive mucosa of the respiratory tract does not tolerate the added irritation of the anesthetic vapor, and laryngospasm, persistent coughing and bronchospasm may result in hypoxia and cardiac arrest. We prefer to wait two weeks and preferably four weeks after an acute infection.
4. Tonsillectomy should not be performed during a poliomyelitis epidemic, since there is accumulating evidence that children who have had recent tonsillectomies are more likely to de-

velop a bulbar type of paralysis if they should contract the disease. However, this does not mean that in the absence of an epidemic a child or adult who is in more than average need of the operative procedure should not have it done. The child with hearing impairment or persistent fluid in the middle ear should have the operation during the summer months provided there is no epidemic in the community.

5. Any systemic disease that increases the risk of the procedure or entails a limited life expectancy contraindicates tonsillectomy. Among these are hemophilia, severe anemia, or any blood dyscrasia, severe or uncontrolled diabetes, hypertension, active tuberculosis and chronic nephritis.

Summary

We are not declaring war on the tonsils. Respect for normal tissue and evidence that the tonsils and other adjacent lymphoid tissue serve a useful purpose in producing immunity and in aiding our defensive mechanism against infection during a period of life when acute infectious diseases are most dangerous, should restrain physicians from indiscriminate surgical removal of tonsils and adenoids.

Since no laboratory test is available to determine whether the tonsils are beneficial or harmful, the clinician's decision must rest on his evaluation of all the factors that contribute to the child's well-being and on the collective experience of his colleagues. There are too many factors to permit rule of thumb decisions. The individual approach must be used in reaching a conclusion in a clinical matter in which full scientific control is impossible.

There can be no doubt about the beneficial effects of removal in well selected cases.

The Growing Interdependence of Medicine and Dentistry

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Dentistry as a profession is still an adolescent and as such is experiencing the growing pains, problems, and misunderstandings of that period in its development. As in any adolescent period the growth has been very rapid—so rapid in fact that it is difficult for many members of the profession of dentistry, as well as members of other branches of the healing arts, to see and accurately evaluate what is happening. In an effort to clarify this situation, it seems wise to review some of the important points in the development of dentistry that may have a bearing on its present status.

Historical Background

The first dental service was an attempt to relieve pain by the removal of an aching tooth. The only professional requirements were a strong arm and a deaf ear. Later it was discovered that decayed and missing teeth could be repaired and replaced, and with this discovery dentistry entered into a long era of pure mechanics. This was a period in which the emphasis was on mechanical perfection with little regard for the fact that these technical procedures were performed on living tissues that reacted to injury just as in any other part of the body. The physiological functions of the jaws and associated structures were ignored or unknown, as were bacterial infection and many other pathologic processes. In 1910 an English physician, William Hunter, indicted American dentistry for the systemic pathology engendered by gold crowns and septic bridgework. During this same period of crude bacteriologic technics and infrequent roentgenographic examinations, Frank Billings and Edward C. Rosenow advanced the theory that dental foci of infection were implicated in the causation of a number of systemic conditions, particularly in diseased conditions of the joints. The acceptance of this theory provided a rosy future for the treatment of arthritis, heart disease and other chronic ailments. As a result teeth were extracted in wholesale lots and countless patients were doomed to go through life with a grossly impaired function of a very important part of their digestive system. Even to this day some men condemn a tooth just because it is covered by a metal

Read before the Annual Meeting of the Kentucky State Medical Association, September 22-24, 1953, Louisville.

crown. Research and clinical observations during the past 40 years have resulted in much doubt as to whether dental and other foci of infection are the causative factors in many systemic diseases which have been attributed to them. The theory as advanced by Billings and Rosenow is certainly not generally accepted at the present time. In 1950 the University of Michigan conducted an extensive workshop program in an effort to evaluate the present thinking on focal infection as a factor in systemic disease. The conclusions of the workshop can best be summarized by a quotation from McGehee[1] "Devoid of their teeth, stripped of their tonsils, often the victim of numerous colonic irrigations, abdominal and genitourinary operations, the patient finally is reduced to only those organs necessary for existence, meanwhile his intraocular disease progresses remorselessly to absolute blindness"; and also a quotation from Hench[2] "It became increasingly difficult to harmonize the microbic theory of the origin of rheumatoid arthritis with the phenomenon of relief of the disease by jaundice or pregnancy. It became easier, rather, to consider that rheumatoid arthritis may represent, not a microbic disease, but some basic biochemical disturbance which is transiently corrected by some incidental biologic change common to a number of apparently unrelated events. . . . ."

The effect of ACTH and cortisone has already caused a considerable revision in the thinking concerning dental foci of infection. The effect of the "alarm" reaction of the pituitary-adrenal system currently is being explored, and it is possible that out of this widespread investigation will come the final critical appraisal of the role of dental foci of infection in systemic disease.

Contributions Made by Dentistry

Considerable time has been devoted to the present concept of focal infections, as this has been and still is a very important common ground in medico-dental relations. As a further background for the growing interdependence of medicine and dentistry it seems logical to enumerate some of the contributions to the healing art which have been made by each profession. Perhaps the greatest contribution made by dentistry was the discovery and use of general anaesthesia. Nitrous Oxide was first administered by a dentist named Horace Wells in 1844. Ether was first administered by a dentist named William T. G. Morton in 1846. Following these discoveries general anaesthesia gradually came into general use and thus it became possible for surgery to make the great advances which it has made since that time.

Another major though little appreciated contribution of dentistry is in the field of diet. From the beginning dentists have tried to fathom the etiology of tooth decay. Extensive research and clinical observations have been made not only of the diets of civilized man but of most of the savage tribes and primitive peoples. From these extensive studies much has been learned about the influence of diet on dental caries and other degenerative processes common to man. From this type of research much has been learned as to why people stay well, for it has long been observed that those who remain in a good state of health and live to a ripe old age are those who, generally speaking, also have a healthy mouth and keep their teeth. Medicine has properly concerned itself with the diagnosis and treatment of disease, and has given little thought to those individuals who have no need for a physician. It is only in recent years that a perfectly well individual regularly consults his physician for a check on his state of health. If no abnormal function or diseased process is found the patient is congratulated and sent on his way, with little or no thought given to why he is in perfect health. In its search for the cause of dental caries dentistry has given much time to the study of those individuals who do not have tooth decay, and has learned much concerning the health pattern of such individuals. It seems logical that the more perfect our understanding of what constitutes normal health and function, the better able we are to understand any deviation therefrom. Dentistry has contributed much in this field, even though it may be misunderstood or at least not properly evaluated.

Dental metallurgical research has also contributed numerous tissue tolerant metals, which have made possible many advances in orthopedics and in the surgical reduction of fractures.

The Contributions of Medicine

While the dental profession is justly proud of its contributions to the health and well being of humanity, it is cognizant and deeply appreciative of the far greater number of contributions made by the medical profession and its closely allied sciences. The first major development in

modern medicine was the perfection of a large number of revolutionary methods of examination. These procedures, which are still being improved and perfected, have made it possible to determine accurately a great many physiological dysfunctions of the human body, and enabled the modern dentist to evaluate the systemic relationship of his oral findings.

Medicine next concerned itself with the study of the bacteria which attack the human body. The bacterial relationship to many disease processes has been definitely established, and medical research is still very much at work developing effective means for the prevention and treatment of bacterial invasions. It was the proof of the bacterial theory of many diseases that gave dentistry the first big push on the road to becoming an important branch of the healing arts. Medicine, by virtue of its experience in dealing with bacteria and their effects, has developed many tried and proved aseptic technics. Without the benefit of these technics modern oral surgery would not be possible.

Another contribution of great value to dentistry and to those whom we all seek to serve is the development of intelligent procedures in the taking of a case history, together with accurate indices for the correct evaluation of the recorded findings.

The fields of psychology and psychosomatic medicine are relatively new but their value and application to the practice of modern dentistry is becoming increasingly important. Many of the problems associated with the treatment of the completely edentulous are psychological and even psychiatric. Dentistry appreciates the help which has been given it in these fields. Time does not permit a complete listing of all the major contributions made by medicine, but they are legion, as are the truths which have been discovered by many of the closely allied sciences.

Biochemistry and Nutrition

Biochemistry and nutrition offer much hope in the eventual solution to the problems of periodontal diseases and dental caries. The sciences of pharmacology and toxicology have made possible the rational use of drugs in the treatment of the various dental disorders. Modern restorative dentistry would not be possible without a thorough knowledge of the anatomy of the associated structures. While medicine cannot take all the credit for these specialized anatomical studies, it certainly did all the original work and furnished the incentive and the technics for further investigations. And finally the practice of dentistry would not be what it now is without the development and present understanding of all the basic medical sciences. Credit for these contributions must go largely to medical or medically sponsored research. With this brief history of major developments and of the contributions made to the art of healing by both medicine and dentistry, it now seems logical to suggest some of the things which each profession can and should do if those whom we seek to serve are to receive the maximum benefits from the application of present day scientific knowledge. The improvements that dentistry can make will be considered first. Dentists must realize their responsibility in the detection of systemic disease. They should be acutely aware of the fact that often they have the first opportunity to detect many incipient diseases, and that they should be able to recognize (or at least suspect) systemic disorders and refer the patient to his physician for treatment. The dentist should realize that the oral cavity is a "mirror" of the rest of the body and the oral tissues are sensitive indicators of the general health status of the individual — thus changes in these structures are frequently the first indication of subclinical disease processes in other parts of the body. This is particularly true in the nutritional deficiencies, endocrine imbalances, gastrointestinal disturbances, and certain of the anemias and blood dyscrasias. Dentists should be able to interpret the image in the mirror, or, in other words, to know what they see. Since dentists are frequently the first to see these patients, their opportunities and their responsibilities are very great.

Dentistry should also recognize that many of the problems presented by their patients are systemic or psychiatric and that these patients will be best served if expert help is sought in these fields. In fact, many dental problems are insurmountable without the close cooperation of a good internist or psychiatrist.

Dentists generally should have a greater understanding of physiology and function in their own fields. They must develop a philosophy that transcends the mere filling of holes and spaces. They should realize that the mouth is often the cause of systemic and mental disturbances, as well as frequently the victim of them.

Dentistry should contribute the knowledge it has gained from many special studies of diet and nutrition, and also its many observations of why people stay well. Much could be added to the present store of general knowledge of degenerative diseases if this were done.

Finally if dentists are to do their full share in the alleviation of human suffering, they should be able to give an accurate scientific diagnosis of oral findings. The physician has a right to expect this, and it is the definite obligation of the dentist to be able to furnish it. Real progress can come in no other way.

Opportunities for Medicine

Some of the things that medicine can and should do may be listed as follows:

First physicians should realize that there are more sick people on the street than there are in hospitals or in their offices. They should also realize that the slogan "See your dentist twice a year" has been far more effective in getting apparently healthy individuals to routinely return for periodic examination than any scheme or system which medicine has so far devised. Thousands of people, free of any symptoms of dental disorders, regularly return to their dentist for a semi-annual check up, though they never see a physician until they are aware of illness or discomfort. This being true, it is obvious that the dentist has a much greater opportunity to detect incipient disease processes than does the physician. If real progress is to be made in preventive medicine, physicians should recognize and utilize this opportunity which they may have to see many diseases in their incipiency and thus more effectually treat them when they are referred.

Importance of Oral Health

The physician should also realize the importance of mouth health to general health; if any part of the body is diseased the whole organism suffers, and the oral cavity is no exception. If digestion and nutrition are important then the mouth, the first organ of digestion, must be important. The oral cavity is analogous to other body cavities with their associated organs. They all are governed by the same physiochemical laws and physiologic principles, and they have a common source of nutrition. However, the oral cavity and its contained structures are in intimate relation with the external environment and are subjected to mechanical, chemical, and bacterial insults that are rarely, if ever, experienced by other body cavities, and they are therefore unusually vulnerable to disease. It is for this reason that certain changes in oral tissue are of special significance.

Physicians should also realize that many obscure neuralgias about the head and neck are due to abnormal mandibular function and that this same abnormal function may influence the physiological function of the eustachian tubes, or induce arthritic symptoms in one or both mandibular joints. The bracing action of the teeth as they occlude in harmonious mandibular relation is necessary for the physiological function of deglutition. This same supporting action of the teeth and jaws is necessary for the best development and harmonious relation of many of the muscles and other soft tissues of the face and neck. The psychiatric implications of altered facial expressions are too numerous to be considered in a paper of this length, but they become of increasing importance when it is realized that much facial disharmony could have been prevented by attaining and maintaining normal function of the oral cavity and its associated structures. Physicians should realize that there is a vast difference between vibrant health and the absence of detectable disease; they must become cognizant of the fact that extensive dental caries or periodontal disturbances are indicators of poor health, even though the medical findings may appear to be negative.

The general lack of appreciation by the medical profession of the importance of oral health is due to serious curricular defects in many medical schools. Many physicians are still prone to consider the oral cavity as the corridor to the tonsils, and their knowledge of dentistry is limited all too frequently by personal experiences which many times are unpleasant.

Another thing that medicine can do is to give the dentist an accurate diagnosis and appraisal of the patient's physical condition, since this knowledge is necessary before the dentist can determine whether his problem is largely systemic, entirely local, or a combination of the two.

Lastly, medicine should realize that the modern dentist is one of the most highly trained specialists in any branch of the healing arts, and while many of his op-

erations and procedures are mechanical, they are no more mechanical than any other branch of surgery; both specialties require a biologic understanding of anatomy, physiology, and pathology in addition to their individual and special technics and training.

Possible Future Developments

Now that an attempt has been made to evaluate some of the major contributions of each profession, and suggestions have been given for a closer and more effective cooperation, it may be well to predict some possible future developments. Both medicine and dentistry have been and still are in an era of control. While it is true that many diseases are prevented by immunization, the major work of both professions is still an effort to control disease processes after they have started. In spite of all this control, 50% of all individuals past fifty are or should be wearing complete dentures; and, in spite of the many and very important scientific advances made by medicine, most of the degenerative diseases are increasing at an alarming rate. The highest aim and ultimate goal of any profession is to eliminate or at least minimize the need for its existence. If this goal is to be approached it is obvious that the next forward step to be taken by both professions must be in the field of prevention. Real progress in this field will require the application of all the known truths concerning preventive measures, and no individual or profession has a copyright on the sum total of this knowledge. All our best minds must be cultivated, and the thoughts and discoveries of these people must be freely given, interchanged, and applied if the greatest progress in the field of prevention is to be accomplished. The highly trained diagnostician will perhaps become of greater importance. He will determine the patient's deficiencies and diseases, and refer him to the proper specialist, whether he be general surgeon, dentist, endocrinologist, or specialist in nutrition. This last specialty of nutrition has been too long neglected by both professions, as it is in this field that the greatest progress will be made in real prevention. Closely associated with nutrition and apparently dependent upon it is the function of the regulators of body chemistry, the endocrines. The cessation of symptoms in some types of arthritis during pregnancy, the rampant dental decay and periodontal disturbances concomitant with adolescence and menopause, and the influence of sex hormones on certain types of cancer—all suggest the very great influence of the endocrine hormones on body chemistry. Dentistry is sure that medical science will discover and perfect accurate methods of diagnosis and treatment of endocrine imbalances. When this is accomplished it is expected that dental caries, periodontal disturbances, and many other degenerative diseases will become less common.

Summary

In this the second half of the 20th Century, when all branches of the healing professions are thinking more of true prevention, let it again be stated that the dentist very often has the first opportunity to observe the need for an individual to see his physician for a complete physical check up. The professions of medicine and dentistry should realize that they are working on the same patients to accomplish the same purpose of preventing disease or restoring the individual to a state of health, and that if the best interest of the public is to be served the application of a wide variety of scientific knowledge may be necessary. The patient should be treated instead of the symptoms, and above all, if the healing professions are to continue to justify the respect and confidence of those whom they seek to serve, they must be interested not in who is right but only in what is right.

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SPECIAL ARTICLES

FIRM GROUND FOR MEDICINE

EDWARD J. McCORMICK, M. D.

President, American Medical Association

Toledo, Ohio

It is always a source of great satisfaction to me to attend a state medical society meeting. For it is at such meetings that I see evidence of the great personal interest physicians take in continuing to raise the standards of medical care in this country.

The people of Kentucky should be proud of the way their doctors responded to the invitations for this annual session of the Kentucky State Medical Association. Their avid interest in the proceedings is gratifying. By coming to this meeting and attending its scientific sessions, these physicians are, in effect, taking a postgraduate medical course.

They came here to learn more about the medical techniques they already know so well. They are learned men who sit for hours listening to other learned men discuss the latest advances in medical science. They take copious notes and talk over with each other the import of the subjects covered. They compare techniques, criticize and are avid propounders of questions that stimulate thinking.

Having accumulated a fund of new and very useful information, they return to their homes and offices armed with additional knowledge that accrues entirely to the benefit of their patients.

They never cease to learn and they always seek to improve their skill. As long as we have men such as these, we never need fear for the future of American medicine. These physicians have made possible the great advances in medical science in the last 25 years. They are doctors who will set the pace for even greater progress in medicine of the future. Eventually, the doctor of medicine will devote most of his time to disease prevention. I am certain that because of their efforts, and the wholehearted cooperation of the general public, diseases such as poliomyelitis and cancer will be added to the long list of other once-dreaded ailments which are now of historical rather than practical interest.

The horizons of medicine are unlimited. Research workers are making magnificent progress in all fields. Spectacular devices such as the mechanical heart and lung and the mechanical kidney demonstrate man's ability to ferret out the long hidden secrets of the human body.

Operations upon the heart, the brain, the lungs and stomach and other vital organs, impossible 25 years ago, are now being accomplished with safety and success. Advances in orthopedic surgery have brought happiness and independence to countless crippled individuals who, a few years ago, could expect nothing more than endless years of frustration, misery and pain. Surgery and radiology are producing an increasing number of cures in cancer cases.

It is a paradox, indeed, that the medical profession should be working so diligently to put itself out of business.

The children of today are chief beneficiaries of this wonderful progress in medical science. They will live longer, be healthier and lead more useful lives.

During the past summer we have read a lot about the mass inoculation of children in polio-stricken communities with gamma globulin. It has been determined that gamma globulin at least temporarily prevents the onset of the dreaded paralytic type of polio. Permanent vaccines against this disease are now being developed, and it is my sincere belief that they will be available for general distribution before too long. Patience on the part of the general public is required in this regard. The safety and effectiveness of the vaccine must be proved beyond any doubt. When the proper time comes the public will be made aware of its availability.

Sometimes we hear that all of the fine advances in medical science are of little value to a lot of people because the new-

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found skills are not generally available. Let me assure you that through the diligent effort of your state and county medical societies, strongly backed by the American Medical Association, steps are being taken to bring the world's best medical care to every part of this nation—every village and every hamlet.

In the United States we have one physician for every 730 persons, more than any other nation. Most state medical societies are now operating placement centers to make the distribution of doctors more efficient. Night and emergency telephone centers have been established by doctors in nearly 700 communities and more are springing up each day.

You, here in Kentucky, through your Medical Association are making notable contributions toward insuring that the ever-expanding benefits of medical science and knowledge reach every citizen. As a rural state it is appropriate that your chief concern should be with rural health problems. The fine beginning made by the Kentucky Rural Health Council which was founded by your Association is to be commended. Your awareness of the economic aspects of medical care has been evidenced by your leadership in the establishment of the Kentucky Physicians Mutual as a part of the Blue Shield program and in the study of indigent care which I understand you are now making.

You have, of course, received national recognition through the work of your Rural Medical Scholarship Fund created under State Medical Association sponsorship. You are demonstrating, as are other state medical societies, that the American medical profession is determined to do everything in its power to see that doctors are placed where they are needed. Your Physician's Placement Committee serves to buttress the splendid work of your scholarship fund for rural doctors.

All this means, of course, that doctors everywhere are doing their utmost to spread today's fine medical care to the entire population of the United States. We all know that there are some great problems medicine has not yet solved. Thousands of experts are spending millions of dollars each year, seeking the answers to these problems in great research centers and medical schools all over the United States, including your own great University of Louisville. Medicine does not have all the answers, does not claim to know all the answers, but medicine will obtain them with your help.

Much of the progress of medical science in this country coincides with the growth of organized medicine. One hundred and six years ago, scattered medical societies throughout the nation joined hands to form the American Medical Association, thereby setting up a democratic procedure for elevating the standards of the medical profession on a uniform basis. Today, the Association is composed of 140,000 doctors who express the medical needs of their respective communities through the representatives they elect to the A.M.A.'s House of Delegates. They spend 10 million dollars each year studying and working in the fields of rural health, industrial health, the availability of physicians, medical care for the armed forces, civil defense, medical education, hospitals, nursing, mental diseases, health education, exposing quacks and fakers and searching for ways to help the chronically ill and those who have trouble paying for medical care. These are only a few of the A.M.A.'s activities.

We have encouraged the development of voluntary prepaid health insurance plans to assist the individual and family in meeting the unexpected costs of sickness. Such plans are being constantly improved to include protection against long-term, disabling illness or injury and to provide coverage without regard to age. There are more than 90 million Americans now carrying hospital, surgical and medical insurance.

As a public service organization, the American Medical Association is proud to proclaim its sincere interest in promoting the highest quality medical care for the people of the United States.

In closing, let me state once more that the doctor who leaves his office from time to time to attend the scientific meetings of his state or county medical society is in reality performing a greater service to his patients. A medical practitioner should make every effort to keep abreast of the latest developments in medical science. And patients who find that their doctor has gone to a medical meeting should remember that they will be the principal beneficiaries of his interest in the activities of the medical groups to which he belongs.

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EDITORIALS

DR. McCORMICK PRESCRIBES "FULL CONFIDENCE"

Edward J. McCormick's, M.D., appeal to physicians everywhere for "action that would restore the full confidence of the public in our profession," which he made as American Medical Association president to that organization's House of Delegates Meeting in St. Louis, forcefully presented a ringing challenge.

"Full confidence" of the public is the great need facing the medical profession today. The peculiar position of medicine as a profession and as a target is such that anything less than "full confidence" represents a real deficiency. The medical profession cannot grow on the sort of limited confidence which might suffice for less dignified or responsible groups.

Emphasizing the critical character of medicine's position today, Dr. McCormick stated that in the last six months he has observed little evidence of change in "the socialistic trend and government intrusion into the business affairs of the people."

Citing the need for action against improper professional conduct by a small minority of physicians, Dr. McCormick explained that he was opposed to a campaign of national publicity that would heap upon "the great percentage of honest physicians....the sins of the few." He added, then, "but we cannot close our minds to the need for some action that would restore the full confidence of the public in our profession.

"Good public opinion cannot be bought. It must be earned through exemplary conduct and genuine service in the public interest. Whatever money the AMA and its constituent societies spend for public education and public relations is wasted unless individual physicians take wholehearted interest in the success of these ventures.

"Doctors must know more of the public thinking regarding fees and physician-patient relationship if we are to continue to exist as free scientists and practitioners.

"We have a policing job to do, and it must be done through the medium of existing disciplinary machinery. It cannot be done in any other way."

Because "many doctors and most laymen know little of the unselfish accomplishments of medical organizations," Dr. McCormick issued a challenge to the AMA House of Delegates to design a better way for bringing to the attention of individual doctors the medical problems of the day.

"Despite our efforts and hard work," he said, "unwarranted criticism comes from many sources due to lack of knowledge on the part of some physicians and laymen of our aims and purposes."

We hope that the AMA House of Delegates can come up with a satisfactory answer to Dr. McCormick's challenge for better information channels. The fact remains, however, that it is extremely difficult to adequately inform those whose basic lack of interest, which is normally a product of original ignorance, makes them inattentive to all approaches.

Because of this, we were especially pleased with the recommendation made by Dr. McCormick in his conclusion that the House of Delegates and the AMA Council on Medical Education and Hospitals should "insist that a reasonable amount of time be devoted by our medical schools to the formal teaching of medical ethics."

Many of the instances of professional conduct which border on malpractice and which may have an equally damaging effect on the public's attitude toward the profession are the results of thoughtlessness and lack of full comprehension of all that medical ethics involves. The responsibility of medical schools in this regard is equally as great in the field of science if they are to serve their students and the public properly.

Every physician should be imbued with the idea that he as a physician must have the "full confidence" of his patients and that his profession must have the "full confidence" of the public. This should begin when he is a student, and he should be reminded of it at every opportunity.

A BARGAIN WELL KEPT

In 1948, the University of Louisville School of Medicine entered into a bargain with the Medical Research Commission, set up for the purpose by the Commonwealth of Kentucky. The consideration for the medical school was an appropriation by the Legislature to be used by the school in medical research.

In exchange for these monies, the school agreed to increase the number of students admitted from Kentucky. A "Report of Progress," recently prepared by the University of Louisville, provides a five year summary of how beneficial the arrangement has been to the state.

That the whole field of medicine is being served scientifically as a result of the continuing appropriations for the Medical Research Commission is indicated by the increase in research projects at the Louisville medical school. In the year prior to the first state appropriation, only 19 research projects were under way; during the past year there were 128 different research projects.

As the "Report of Progress" points out, not all of these are carried on through state funds. Grants from private industry, educational foundations and other sources have played their part. The willingness of such sources to provide money for research apparently was greatly influenced by the willingness of the legislature to make its appropriations.

The product of this research is, of course, no static thing. It reaches the practicing physicians of Kentucky and thereby is reflected in the constant further improvement of medical care being received by our patients. Were this the only tangible result of the Medical Research Commission's work, the total $700,000 spent by it in the past five years could only be described as a sound investment for the people.

In addition, however, the University of Louisville has more than fulfilled its moral obligations by training a substantially increased number of Kentucky men and women in medicine. Prior to its agreement with the Medical Research Commission, the medical school annually admitted about 90 students, only one-half of which were Kentuckians. Most of these were from Jefferson County.

Today, five years later, admissions have been increased to about 100 annually. The percentage of Kentuckians has at the same time been substantially increased with special attention to those outside of Louisville.

Of 383 students enrolled in 1952-53, 334 were from Kentucky. Of these only 112 were from Jefferson County and 222 were from out-state. The geographic spread accomplished through this deliberate effort to give greater medical education opportunities to young men and women outside of Louisville is emphasized by the fact that 79 different Kentucky counties were represented.

They are spread from one end of the state to the other. If they can be induced to return to their home counties when they are ready to enter practice, much of the physician-distribution problem in Kentucky will be solved.

The 334 Kentuckians are being trained as physicians with the hope that they will actually enter practice in the Commonwealth at a total annual cost of less than $250,000 to the state. There is considerable justification for the "Report of Progress" to pridefully claim that no other state has so big a bargain in the field of medical education. The University of Louisville deserves full congratulations on the exemplary manner in which they have lived up to the trust accorded them by the Legislature. The Legislature deserves commendation on the wisdom of its action in making this bargain possible for Kentucky.

President's Page

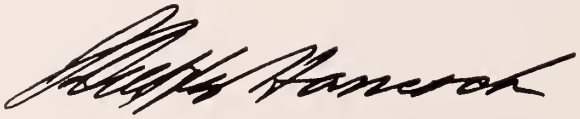
There are some physicians who think that medical organization is unnecessary and that it tends to foster a hierachy which takes delight in trying to tell others what to do and how to do it. This is certainly contrary to the facts so far as our state organization is concerned.

Policies to be followed are determined by our House of Delegates. The officers who carry out those policies are elected by the same delegates. A delegate must follow the instructions of his county society. The majority of individual members in any county society determine the path for their delegation to follow. Inefficient delegates can be replaced at the end of a two year term. Contrary to the opinion of some, those counties with small membership rosters have proportionally more representation than the larger.

The Council, also composed of men elected by the House, is simply an interim committee to give continuity to the function of the State Association. Its actions are embodied in its report which may be accepted or rejected in toto or in part by the members of the House of Delegates. There is no truer democracy than that which exists in our State Association.

Both tangible and intangible benefits of organized action have been discussed before in this column. For the present your attention is directed to those meetings which are scheduled for the immediate future. They include a Rural Health Conference, a County Society Officers Conference and various Councilor District Meetings.

Nothing will take the place of your presence at those meetings. Nothing will contribute more to the democratic representative action of those groups. Everyone is urged to attend and to express himself in the consideration of various policies which will be presented. With the continual back-door and fringe attacks that our profession is being faced with, it is of utmost importance for our association to move forward in unity and harmony.



PRESIDENT

ORGANIZATION SECTION

Kentucky Rural Health Conference Draws Prominent Leaders

A combination of national, state and local leaders, prominent in rural and health affairs, will discuss the theme "Helping Yourselves to Health" at the 1954 Kentucky Rural Health Conference to be held at the Kentucky Hotel, Louisville, March 10 and 11, under the sponsorship of the Kentucky Rural Health Council and the Kentucky State Medical Association, it has been jointly announced by Walter L. O'Nan, M.D., health council chairman, and Wyatt Norvell, M.D., New Castle, KSMA Rural Health Committee chairman.

Registration for the conference will be at 12:30 p.m., Wednesday, March 10; adjournment will be at noon, Thursday, March 11. A nationally known speaker will be scheduled for the dinner at 6:30 p.m., March 10. Clarence Miller, prominent farmer from Shelby County, will discuss the Rural Kentucky Medical Scholarship Fund at the same session.

Farm and home safety, determining community health needs, procurement of physicians and nurses, and voluntary health insurance will be discussed at the afternoon session. Maynard H. Coe, Chicago, farm division director of the National Safety Council; Professor Charles A. Walton, Louisville, University of Kentucky College of Pharmacy; Ida Hagman, Lexington, University of Kentucky Extension Division, and Horace Cleveland, New Castle, Henry County farm leader, will discuss the session's major topic, farm safety.

Bruce Underwood, M.D., secretary and general manager of the KSMA, will make a major talk. Other Wednesday speakers will include Kathryn Ernestes, Louisville, president of the Kentucky League for Nursing; J. Duffy Hancock, M.D., Louisville, KSMA president, and Layne Tines, Louisville, executive director of Kentucky's Blue Cross and Blue Shield plans.

The final session, Thursday morning, will emphasize the importance of voluntary cooperation in solution of community health problems and how the rural health council movement, working through local councils, serves in this field. Speakers at this session will include Ben Adams, Frankfort, Kentucky Commissioner of Agriculture; Aubrey Gates, Little Rock, Arkansas, AMA Rural Health Council field director; and J. E. Stanford, executive secretary of the Kentucky Farm Bureau Federation.

Highlight of the Thursday morning session will be reports from the field by Kentucky communities that are now working to solve their own health problems through voluntary cooperation. These reports will include Adair County, Henry County, Menifee County, and Robertson County.

Presiding officers at the conference's three sessions will be Wyatt Norvell, M.D., New Castle; Burl S. St. Clair, Falls of Rough, president of the Kentucky Farm Bureau Federation, and Myrtle Weldon, Lexington, state leader of Home Demonstration Agents and vice-chairman of the Kentucky Rural Health Council.

"The success of the conference depends in large measure on large attendance and participation by rural lay leaders," Dr. Norvell said in urging every physician to come if possible, but in every instance to invite other leaders in his community.

The conference program committee, under the leadership of Mrs. Cynthia Warren, executive secretary of the Kentucky State Registered Nurses Association, has done its job well. The material presented will be of real value to everyone interested in health.

"The KSMA Auxiliary under the leadership of its president, Mrs. Clyde C. Sparks, Ashland, president-elect, Mrs. Karl Winter, Louisville, and Rural Health Committee chairman, Mrs. Garnett Sweeney, Liberty, are making a serious effort to insure a good attendance of laymen by urging each auxiliary member in the state to bring a car full of leaders from among the farm men and women in her own community.

"Where it is possible for physicians to attend, and we cannot over-emphasize its importance, they can do well to follow this example. The conference and the Kentucky Rural Health Council are major projects of the Association. Their benefits can only be realized through work at the local level.

"Everyone interested in rural problems is invited to attend. KSMA members can do much through encouraging lay leaders to come to Louisville March 10 and 11, and see how they, too, may 'Help Themselves to Health,' through voluntary cooperation on the community level."

Dr. Hancock Assumes Presidency of Surgical Congress

J. Duffy Hancock, M.D., Louisville, KSMA president, will be inaugurated as 1954 president of the Southeastern Surgical Congress at the 22nd annual assembly, March 8-11, 1954, Dinkler-Tutwiler Hotel, Birmingham, Alabama.



Dr. Hancock

Dr. Hancock was elected president by the Congress, which is composed of representatives from 12 states, during the 21st annual meeting in Louisville in March, 1953. He will succeed J. R. Young, M.D., Anderson, South Carolina.

Two Kentucky surgeons, John T. Bate, M.D., Louisville, and Franklin Jelsma, M.D., Louisville, will participate in the scientific program, speaking on "Repair of Inguinal Hernia in the Middle Aged Industrial Laborer," and "Some Complications of Head Injuries," respectively.

"The March 1953 meeting, held at the Brown Hotel, Louisville, was one of the best attended annual assemblies of the Congress on record, with over 500 physicians attending," according to Dr. Hancock.

"We expect the 1954 spring assembly to be even more successful," he continued. "Fifty two scientific papers will be presented, of which number, 24 will be delivered by outstanding guest speakers from all over the nation."

Other features of the scientific program will include four panel discussions: "Traumatic Lesions," "Esophagogastrointestinal Hemorrhage," "Liver and Gallbladder Pathology," and "Surgical Management of Peptic Ulcer."

Post-graduate Education Plan Accepted by Council

A plan for a comprehensive post-graduate medical education program was accepted by the Council, December 17, 1953, at the recommendation of the KSMA Committee on Medical Education, Lawrence T. Minish, Jr., M.D., Louisville, chairman.

In his report to the Council, Dr. Minish proposed the establishment of a post-graduate medical education bureau in the KSMA headquarters office. Qualified physicians would be enlisted from various medical centers in the state to participate in medical seminars, forums, panels and to serve as speakers.

Under this plan, "package programs" would be available for use by medical groups as needed. Participating physicians would be allotted sufficient time to prepare material adequately in advance. On the receiving end, the "consumer" would have a choice as to the type of program and the particular speaker he wished to hear.

Council assistance will be needed in helping the committee to secure outstanding physicians for the programs and in supporting the selling aspects of the educational plan, Dr. Minish stated.

Industrial Health Congress Meets Feb. 23-25, in Louisville

Health problems of the worker and his family will keynote the program of the 14th annual Congress on Industrial Health, to be held February 23-25, 1954, at the Brown Hotel, Louisville, sponsored by the American Medical Association's Council on Industrial Health, according to Gradie R. Rowntree, M.D., Louisville, program chairman.

At the opening general session on February 24, the role of industry in the maintenance of the health of the nation will be the subject, emphasizing that industry and medicine are partners. A clinic on health programs for executives will be presented at the afternoon session, along with a discussion of the value of screening examinations.

The Jefferson County Medical Society with the members of the Congress will co-sponsor an open dinner meeting, Wednesday evening, February 24, Crystal Ball Room, Brown Hotel. A special feature will be the presentation of the President's Award to the physician making the most outstanding contribution to employment welfare of the handicapped in 1953.

Problems of a small plant operator will be considered at the second morning session, February 25, with the assistance of the National Safety Council's small business and associations committee.

In 1953, the 13th annual Congress on Industrial Health convened at the Drake Hotel, Chicago, January 20-22. This year's session is expected to attract more than 600 physicians, and other groups interested in the health of the industrial worker, said Carl M. Peterson, M.D., Chicago, secretary of the Council. All KSMA physicians are invited and urged to attend.

A joint session with the AMA's Council on National Emergency Medical Service to discuss community preparations for meeting a disaster

(Continued on page 136)

Program

Fourteenth Annual Congress on Industrial Health

Sponsored by the American Medical Association

Brown Hotel, Louisville **February 24-25, 1954**

OPENING GENERAL SESSION

Wednesday, February 24

9:30 Keynote Address: Industry and Medicine - Partners in Health

Speaker to be announced

Panel Discussion: A Medico-Social Problem of Modern American Life

Moderator: William P. Shepard, M.D., New York

Participants: Edward Bortz, M.D., Philadelphia
Leo Bartemeier, M.D., Detroit

12:00 Intermission

AFTERNOON SESSION

Wednesday, February 24

Section One

Lemuel McGee, presiding

KEEPING WELL PEOPLE WELL

2:00 Are Workers Getting Healthier?

Frank Dickinson, Ph.D., Chicago

Making Physicial Examinations More Effective in Industry and the Community

Speaker to be announced

A Preventive Medical Program in the du Pont Company

Participants: Allan Fleming, M.D., Wilmington
George Hogshead, M.D., Nitro, W. Va.
Alfred Pennington, M.D., Wilmington
Frederick Dershimer, Washington

5:00 Adjournment

Section Two

O. A. Sander, M.D., Milwaukee, presiding

EMPHYSEMA

2:00 Clinical Aspects

George Wright, M.D., Cleveland

Pathologic Physiology

Ward Fowler, M.D., Rochester

Histo-pathology

Marvin Kuschner, M.D., New York

Therapy

Frank Princi, M.D., Cincinnati

5:00 Adjournment

ANNUAL DINNER

With the Jefferson County Medical Society

Wednesday Evening, February 24

National Award for 1953

To the physician making an outstanding contribution to employment welfare of the handicapped.

Who's Disabled?

A dramatic presentation of what is left, not what is lost.

MORNING SESSION

Thursday, February 24

KEEPING PEOPLE AT WORK

9:00 A Small Plant Operator Consults the Experts

Moderator: H. F. Reinhard, New York City

Participants: Warren Cook, Ph.D., Ann Arbor
Mrs. Gay Merrihue, R.N., New York
John Gibson, Washington, D. C.
Carl Olson, M.D., Chicago

11:00 The Plant Prepares for Emergencies

(Demonstration of first aid and follow-up procedure arranged with assistance of the Louisville Chapter, American Red Cross.)

12:00 LUNCHEON WITH LOUISVILLE ROTARY CLUB

Address: Are We Prepared?

Val Peterson, Director, Federal Civil Defense Administration, Washington, D. C.

AFTERNOON SESSION

Thursday, February 25

JOINT SESSION WITH THE COUNCIL ON NATIONAL EMERGENCY MEDICAL SERVICE

James Sargent, M.D., Chicago, presiding

2:00 IF MAJOR DISASTER STRIKES

Atomic Bombing

James Sterner, M.D., Rochester

Bacterial Warfare

John Phair, M.D., Cincinnati

Chemical Warfare

Colonel James Defandorf, Washington

Psychological Warfare

Ozro Woods, M.D., Washington

3:00 Is Our Community Prepared?

Speaker to be announced

3:30 HOW WE FACED UP TO DISASTER
Preparation and Organism

Lawrence Long, M.D., Jackson, Mississippi

Industry and Medicine - the Indispensable Disaster Team

George Martin, M.D., Vicksburg, Mississippi

Dr. Griffith Retires at 86 after 66 Years of Practice

D. M. Griffith, M.D., Owensboro, a past president of the Kentucky State Medical Association in 1907, after practicing 66 years, retired December 29, 1953.

Dr. Griffith, who is 86 years of age, has practiced 64 years in the same office in Owensboro. He was graduated from the Medical Department of Tulane University in 1888.

The physician in the United States who holds the record for the greatest number of years of active practice is Edmund B. Montgomery, M.D., of Quincy, Illinois, according to a recent issue of the Secretary's Letter of George F. Lull, M.D., secretary and general manager of the AMA. Dr. Montgomery is 95 years old and has practiced for 75 years.

Gamma Globulin Labels Changed

In the future, solutions of gamma globulin will be labeled "Poliomyelitis Immune Globulin (Human)," instead of "Immune Serum Globulin (Human)," according to U. Pentti Kokko, M.D., director, Division of Communicable Disease Control, State Department of Health.

"This new label and package insert indicate that the product is intended for use in the prophylaxis of measles and infectious hepatitis as well as poliomyelitis," Dr. Kokko continued.

Since the gamma globulin allocation for Kentucky is limited, the local health departments are the sole distributing agents for the solutions. They may release gamma globulin to practicing physicians only upon receipt of a regular request form.

AMA President-Elect to Speak at Lexington Session, April 15



Dr. Martin

American Medical Association President-Elect Walter B. Martin, M.D., Norfolk, Virginia, will be the luncheon speaker at the fourth annual County Society Officers Conference at the Phoenix Hotel in Lexington, Thursday, April 15, 1954.

J. Duffy Hancock, M.D., Louisville, KSMA president, who made the announcement said there would be a number of other top ranking, nationally known men who would be presented at the annual conference.

Frank E. Wilson, M.D., hard working, young director of the AMA Washington office, will also be on the program, the KSMA chief said. Dr. Wilson will discuss matters of vital importance that are happening on Capitol Hill.

Complete program details in the March Journal will reveal "presentations that will challenge the interest of every county society officer," Dr. Hancock said.

"In addition to a discussion of national problems of local interest, much of the program will deal with everyday practical problems faced by our county officers."

Trend of 1953 Diabetes Reports Indicates Successful Drive

The 1953 Diabetes Detection Drive, sponsored by the KSMA, will again surpass previous drives if the trend established by the first 59 reporting counties continues, Carlisle Morse, M.D., Louisville, Diabetes Committee Chairman, reported at the first of the year.

A total of 23,563 urine sugar tests were given during the drive which was held November 15-21, as a part of the National Diabetes Week under sponsorship of the American Diabetes Association, the KSMA, and the respective county medical societies. This is 5,485 more tests than were reported for the same counties in the 1952 campaign.

"Although results are still far from complete, 78 unknown victims of diabetes were discovered, according to reports from 59 coun-

ties," Dr. Morse said. "This is an increase of 28 over the number detected in 1952.

"If the trend prevails, the total number of newly discovered diabetics for the whole state may be in the neighborhood of 300 for this year's drive. The Diabetes Committee in each county medical society and all participating members are to be commended on the excellence of their work," Dr. Morse concluded.

AMA House Adopts Resolution On Payment of 1950 Dues

The following resolution was adopted by the AMA House of Delegates at the St. Louis Clinical Session, December 1-4, 1953, relating to the payment of 1950 membership dues in the American Medical Association:

"RESOLVED, that any active member of the American Medical Association who failed to pay dues for the year 1950, and who was suspended for such delinquency, may be reinstated during the first six months of 1954 by payment of 1954 dues only.

"Should such an individual fail to pay his 1954 dues by July 1, 1954, he shall continue to be considered delinquent."

Complete information on the resolution and its effects is being sent to each county medical society secretary in Kentucky, according to Frank V. Cargill, director of the AMA department of records and circulation.

"ADA Forecast" Aid to Physicians And Diabetic Patients

Physicians throughout the country have found the "A.D.A. Forecast" to contain valuable information concerning the many problems which arise in the proper management of diabetics. An authoritative publication, the "Forecast" is edited by Frederick W. Williams, M.D., one of the founders of the American Diabetes Association.

Typical articles in recent issues include "Marriage and the Diabetic," "The Gentle Art of Job Hunting—for Diabetics," "Help Others to Learn What You Have Learned," and "How to Live with Chefs and Like It."

Subscriptions are available at $2.00 a year, $3.50 for two years or $4.75 for three years. The "Forecast" is published bi-monthly by the American Diabetes Association, 11 West 42nd Street, New York 36, New York. Sample copies and subscription forms are available without cost to any physician for use with his patients.

National Rural Health Conference Features Dr. Greenwell

Joseph I. Greenwell, M.D., New Haven, named "Outstanding General Practitioner of the Year," by the AMA in December, 1953, will participate in the program of the 9th annual National Conference on Rural Health to be held in Dallas, Texas, March 4-6, 1954, reports the AMA.

The roles of community planning, cooperative efforts, nutrition and insurance in the maintenance of healthful conditions in agricultural areas will be discussed by the conference, which is sponsored by the American Medical Association's Council on Rural Health.

Featured speakers on the program include Edward J. McCormick, M.D., and Carll S. Mundy, M.D., both of Toledo, Ohio. Dr. Mundy will sound the conference keynote—"Let's Put More 'U' in CommUnity."

Radioisotope Lab Opens Dec. 21, General Hospital, Louisville

An official opening of the $56,000 Radioisotope Laboratory of the University of Louisville School of Medicine was held December 21, 1953, on the second floor of General Hospital, Louisville, where the new unit is located, according to Herbert D. Kerman, M.D., director.

Interested physicians and laymen had an opportunity to view the facilities available in the 9 room laboratory as well as the research division to be used in developing new methods of applying radioisotopes. J. Duffy Hancock, M.D., Louisville, president of the KSMA, represented the association at the opening.

Marshall Brucer, M.D., chairman of the Medical Division, Oak Ridge Institute of Nuclear Studies, was present at the opening and later spoke at the regular meeting of the Jefferson county medical society.

A by-product of atomic energy, radioisotopes will be used in the treatment of cancer, thyroid therapy, and for control of disease by diagnostic, therapeutic and research methods.

Dr. Hoffman Serves PR Committee

Robert J. Hoffman, M.D., South Fort Mitchell, was appointed to serve on the KSMA Public Relations Committee by the Council which met December 17, 1953, in Louisville. Dr. Hoffman filled the position formerly held by C. Walker Air, M.D., Ludlow, who resigned in the fall of 1953.

Audio-Digest Foundation Started By California Association

The California State Medical Association's House of Delegates recently voted to establish a subsidiary, non-profit corporation, called Audio-Digest Foundation, which will make medical literature and lectures available in a new dramatic form.

Current material will be summarized and distributed to physicians throughout the world by means of a system of tape recordings and synchronized visual slides of film strips.

Three types of service will be rendered by Audio-Digest: (1) a weekly one-hour tape summarizing current medical literature, (2) a complete medical lecture library, (3) tape recordings from leading school professors in the nation's 79 medical schools.

Dr. Emile Holman Awarded Yandell Medal

On November 11, 1953, the Louisville Surgical Society awarded the first annual David W. Yandell Medal to Dr. Emile Holman, Professor of Surgery at Stanford University, San Francisco.

The annual award and lectureship were instituted to honor the memory of David W. Yandell, founder of the Society, who was Professor of Surgery in the University of Louisville School of Medicine from 1869 to 1898.

Several surgical conferences were conducted at the University of Louisville by Dr. Holman preceding his presentation of the annual Yandell lecture.

Licking Valley Society Installs Dr. Waldrop as President

C. C. Waldrop, M.D., Williamstown, was installed as president of the Licking Valley Medical Society during the winter meeting held at the Town and Country Restaurant, Covington, December 10, 1953. Thirty physicians and six guests attended the luncheon meeting.

"Diverticulitis and Diverticulosis of the Colon" was discussed and illustrated with lantern slides by M. M. Zinninger, M.D., professor of surgery at the University of Cincinnati. William H. Cartmell, M.D., Maysville, also participated in the scientific program.

Lenore Patrick Chipman, M.D., Williamstown, was installed as secretary-treasurer of the district society, which has held regular meetings since 1930. Postgraduate instruction from lectures by specialists in different fields of medicine has been provided for the rural physicians in northern Kentucky by the society.

A silent tribute was offered to the memory of Luther Bach, M.D., president of the Licking Valley Medical Society in 1938, who was for many years an active member prior to his death November 28, 1953. March is the month set for the next meeting of the district society.

Dr. Bauer Heads AMEF

Louis Bauer, M.D., secretary-general of the World Medical Association and immediate past president of the AMA, was elected president of the American Medical Education Foundation at the AMA Clinical Session in St. Louis, December 1-4, 1953, according to the AMA Secretary's Letter.

Dr. Bauer was a luncheon guest at the first KSMA County Society Officers Conference in 1951, which met in Louisville. George F. Lull, M.D., secretary and general manager of the AMA, was elected vice-president of the Foundation, which was founded in 1950 to help relieve the financial strain of the medical schools by soliciting contributions.

Bookmobiles to Receive Magazine

On request of the Woman's Auxiliary to the KSMA, the Council has agreed that a subscription to the AMA publication, "Today's Health," be presented to each of the 93 bookmobiles which will travel throughout the state lending reading material to Kentuckians who do not have adequate library facilities. The decision for the KSMA to sponsor this project was reached at a meeting of the Council, December 17, 1953, in Louisville.

Dr. Manlove Moves to Colorado

Francis R. Manlove, M.D., recently left the AMA headquarters staff to become director of the medical center and dean of the department of medicine at the University of Colorado School of Medicine, Denver. Dr. Manlove assisted in a survey on medical education facilities in Kentucky in 1951.

Walter S. Wiggins, M.D., assistant dean for graduate and postgraduate medical education at the State University of New York, Syracuse, since 1951, took Dr. Manlove's position with the AMA in January.

Washington News Digest

Washington, D. C. — Although the budget, defense and farm policy are monopolizing Washington headlines, Congress is paying more than casual attention to the health and social security fields. In these, as in other legislative areas, it has for its guidance a specific program, laid down by President Eisenhower in his various messages during the first few weeks of the session. The question now is whether this closely-divided Congress will have the time and/or the inclination to follow through on everything the Administration wants.

Before Congress settled down to its task, the President met with a group of American Medical Association leaders, who discussed with him the Association's position on several important pieces of legislation. Present at the White House meeting, in addition to Mr. Eisenhower and Sherman Adams, Assistant to the President, were AMA President Edward J. McCormick, Trustees' Chairman Dwight H. Murray, President-Elect Walter B. Martin, and Washington Office Director Frank E. Wilson.

Congress got into the health and welfare field with no waste of time. Within five days after Congress reconvened the House Interstate and Foreign Commerce Committee, under the chairmanship of Rep. Charles Wolverton (R., N. J.), began an exhaustive series of hearings on voluntary health insurance, further evidence that the Administration is determined to get some action in this direction.

Chairman Wolverton as long as four years ago was interested in legislation to help prepaid insurance programs extend their coverage and increase their benefits. In 1950 he incorporated his ideas in a bill, but it was not acted upon by the committee and was not revived until this year. Now the atmosphere is much more favorable for Mr. Wolverton's proposal. Not only is he chairman of the committee and his party in control of Congress, but his ideas have strong support from the Administration.

Basically the Wolverton idea is an FDIC for voluntary health insurance. In about the same way the Federal Deposit Insurance Corporation insures bank deposits up to a certain limit, the Wolverton program would insure (or re-insure) various types of hospital, surgical, and medical insurance programs. The proposal is for the federal government to set up a national health insurance underwriting corporation. To keep the corporation going, the member plans would contribute a certain percentage of their gross receipts, possibly 2%.

With the national corporation underwriting unusual risks, the individual programs could offer catastrophic or "complete" coverage. By scaling individual premiums to the family income, the member plans also could offer protection to families with very low incomes. The national corporation would pay possibly two-thirds of each subscriber's claim in excess of, say, $500 or $1,000 in any one year.

Another piece of legislation, receiving favorable attention, also would help families with their medical expenses—a proposed liberalization of income tax deductions allowed for medical expenses. Under present law, only that part of medical expense exceeding 5% of taxable income may be deducted. The pending legislation would drop this to probably 3 per cent, and raise or eliminate the maximum limit. In past years scores of bills pointed in this direction have been introduced. If this is incorporated in the general tax overhaul legislation, it is believed to have a good chance of enactment.

Secretary Hobby's Department of Health, Education and Welfare is firmly behind a proposal to have the federal government show more leadership in vocational rehabilitation of the handicapped. At this writing it is too early for any good indication as to whether physicians will be brought under social security. The Administration's bill would blanket in most self-employed groups, including dentists, attorneys, architects and farmers, in addition to physicians. Rep. Carl Curtis (R., Neb.), chairman of the subcommittee which investigated social security, apparently feels the same way. However, a substantial number of the members of the House Ways and Means Committee, which must pass on the bill, are known to feel that compulsion should not be used on groups that do not want Old Age and Survivors Insurance.

From all indications available during the first few weeks of Congress, a showdown fight may be unavoidable on medical care for military dependents. Defense Department, with support from the President, wants dependent care extended and made uniform among the three services, with military physicians carrying as much of the responsibility as they can. Under the Defense Department plan, dependents who could not be taken care of at military installations would be allowed to obtain their care from private sources, with the government paying almost all of the cost.

(Continued on page 136)

County Society Reports

CALLOWAY

The monthly meeting of the Calloway County Medical Society was held in the chapel of the Murray Hospital on December 7, 1953, with Charles Clark, M.D., president, presiding.

The following physicians were present: A. D. Butterworth, M.D., Charles Clark, M.D., Robert Hahs, M.D., J. L. Hopson, M.D., J. C. Hart, M.D., Hugh Houston, M.D., C. H. Jones, M.D., C. C. Lowry, M.D., J. A. Outland, M.D., Kenneth Ross, M.D. Karl E. Warming, administrator, also attended.

Dr. Houston advised that any new books on cardiology, to be added to the local heart library, could be obtained upon request. Dr. Butterworth moved that an ad on the Blue Cross and Blue Shield Plan be placed in the newspaper once a month. The motion carried.

Dr. Hahs moved that the secretary pay $64.00 for an ad that the society had for the dedication of the Health Center. The motion carried.

The new officers for Calloway County Medical Society are:

C. C. Lowry, M.D., president; A. D. Butterworth, M.D., vice-president; J. L. Hopson, M.D., secretary-treasurer, who was elected in 1953 for a two year term. John Quertermous, M.D., and J. A. Outland, M.D., were elected delegate and alternate delegate, respectively, in 1953 for a two year term.

Charles Clark, M.D., President

GRANT

The Grant County Medical Society met December 18, 1953, in the home of C. C. Waldrop, M.D., Williamstown. The following attended: O. A. Cull, M.D., Smith Gibson, M.D., R. E. Kinsey, M.D., F. R. Scroggin, M.D., C. C. Waldrop, M.D., Virginia Kratz, M.D., Robert Kratz, M.D., Lenore P. Chipman, M.D., and Mr. Everett Chipman.

Dr. Gibson, president of the society, presided over the program which was informal and included a discussion of the problems related to the practice of medicine in the community.

In discussing medical and hospital insurance, Dr. Kinsey said that people should be educated on the type of insurance best for them to buy. It was brought out that many patients believed that they purchased hospital insurance care, but when the policy was read carefully, they often learned that only a small part of the bill was covered.

Others had been mislead in purchasing care for only certain rare illnesses such as diphtheria and poliomyelitis, while the more common illnesses such as pneumonia, gastroenteritis, surgical emergencies and fractures were not covered by their policy.

Dr. Kinsey moved that the secretary obtain from the KSMA information on types of medical and hospital policies available to the public.

Dr. Gibson stated that he would be unable to serve as delegate to the KSMA meeting in 1954 and requested that nominations be made for a substitute. Dr. Chipman was elected delegate, and Dr. Kinsey was elected alternate delegate.

Lenore Patrick Chipman, M.D., Secretary

JEFFERSON

The 473rd meeting of the Jefferson County Medical Society was called to order October 19, 1953, in the Terrace Room of the Kentucky Hotel, by the president, Arthur T. Hurst, M.D.

The minutes of the previous meeting were read and approved. No new members were submitted for presentation or election.

The scientific portion of the meeting was called to order prior to the opening of the business session. H. Burl Mack, M.D., introduced the speaker, William Hilderbrand, M.D., president-elect of the American Academy of General Practice, who spoke on "You and Your Public."

A report of the Executive Committee was read by J. Andrew Bowen, M.D., chairman. V. Edward Masters, M.D., reported on the progress of the Infant and Maternal Mortality Committee, requesting more complete information on filling out the forms. Joseph Frehling, M.D., urged the membership to support the Community Chest drive.

A motion to limit debate on the business to appear before the Society was made by Robertson O. Joplin, M.D. It passed with a two-thirds majority.

Charles G. Bryant, M.D., moved that balloting for the meeting be by closed ballot. Clyde H. Foshee, M.D., seconded the motion. Charles F. Wood, M.D., proposed an open ballot. John T. Bate, M.D., moved to amend the motion by requiring a signed ballot, then withdrew his motion. Put to vote, the motion failed to pass by the required two thirds majority.

The motion to amend the by-laws by establishment of a Grievance Committee within the

Judicial Council was brought before the house. K. Armand Fischer, M.D., spoke for the Judicial Council in opposing inclusion of laymen on the proposed committee.

Oscar O. Miller, M.D., offered a substitute motion: "that there be appointed by the president from among the various specialists including general practitioners, a special committee of members to be named the Professional Relations Committee, whose duties shall be to adjudicate differences between patients and physicians."

Lanier Lukins, M.D., seconded. Carol Witten, M.D., rose to a point of order. The president ruled the motion in order. Charles Wood, M.D., rose to a point of order and Dr. Hurst again ruled the amendment to the motion to be in order. Dr. Bryant suggested that the Committee be named the "Arbitration Committee." Dr. Wood moved that the amendment originally moved be tabled. Dr. Joplin seconded the motion. The motion was defeated. Dr. Miller's motion was then passed by a standing vote.

The amendment to the constitution was then brought forth. Dr. Bowen gave a historical summary of the reasons prompting the Executive Committee's recommendation for the proposed by-law changes. This was passed by a standing vote of the necessary two thirds majority.

The amendment to change the by-laws was presented and after discussion was passed. A simple majority was enough to amend.

The articles of incorporation proposal to amend to conform with the by-law changes was then brought forward. This passed by more than the necessary two thirds vote. There were 271 members present at the meeting.

John S. Llewellyn, M.D., Secretary

McCRACKEN

The annual dinner meeting of the McCracken County Medical Society was called to order at the Ritz Hotel with George Widener, M.D., president, presiding.

R. W. Harrison, public service director of the Blue Cross - Blue Shield Plan, led a discussion on the plan which was followed by a question and answer session.

Walter Johnson, M.D., next discussed the Radio Seminar program and the tentative plan for its execution. It was moved by W. P. Hall, M.D., and seconded by William Smith, M.D., that when the program is printed the announcement will include only the names of the participating physicians, and not their particular qualifications. The motion carried.

The following officers were elected: W. E. Sloan, M.D., president; Goodloe Sargent, M.D., vice-president; M. W. Fowler, Jr., M.D., Secretary; Leon Higdon, M.D., delegate, Harry Abell, Sr., M.D., alternate delegate, Errett Pace, M.D.

A discussion was led by J. Vernon Pace, M.D., on the society's feeling about merging or combining with other neighboring societies. No definite conclusions were formulated.

M. W. Fowler, Jr., M.D., Secretary

PIKE

The regular monthly meeting of the Pike County Medical Association was held on Tuesday, December 15, 1953, in Pikeville, Kentucky. There were seventeen members and six guests present.

The guests were: Dr. Shipley of the United Mine Workers Welfare Administration, Dr. Simmons and Dr. Scheiscissman of the United States Public Health Service from Atlanta, Georgia, Dr. Kokko of the Kentucky State Medical Association and Dr. Pollack and Dr. Walters, externs from the Pikeville Methodist Hospital.

The meeting was called to order by C. C. Rutledge, M.D., president. T. I. Doty, M.D., moved that all members pay their Pike County annual dues of $45 by March 15, 1954. The motion was seconded and carried.

A discussion was led by M. K. Mantooth, M.D., in regard to unlicensed midwifery in Pike County. Dr. Mantooth brought to the attention of the association that there are several unlicensed midwives who are at present practicing in Pike county. The patients of these midwives have had considerable difficulty with puerperal sepsis, he said. It was the general opinion of the association that all midwives should be required by state law to be licensed prior to engaging in active practice.

As a convenience to the members of the society, it was decided that meetings in the future should be conducted as follows: informal meeting beginning at 6:30 p. m., dinner at 7:15 p. m., and formal meeting beginning promptly at 8:00 p. m.

A. G. Osborne, M.D., was appointed delegate to the Kentucky State Medical Association, with T. I. Doty, M.D., serving as alternate. The program committee consists of G. N. Combs, M. D., chairman, with Ralph Allen, M.D., and William Hambly, M.D. The following were appointed to serve on the Publicity Committee: W. F. Clarke, M.D., chairman, along with R. H. Davis, M.D.

A film on the treatment of burns, which was made and supplied by John C. Weeter, M.D., Louisville, was shown at the meeting. This film had recently been shown by Dr. Weeter at a meeting of plastic surgeons in San Francisco, California. Dr. Weeter planned to meet with the association and conduct a discussion following the film, but, due to road conditions, he was unable to attend.

R. H. Davis, M.D., Secretary-Treasurer

SCOTT

The Scott County Medical Society held its monthly meeting on December 10, 1953, at the John Graves Ford Memorial Hospital in Georgetown, Kentucky. The following members were present: Doctors F. W. Wilt, C. R. Lewis, P. H. Crutchfield, W. S. Allphin, H. G. Wells, A. F. Smith, E. C. Barlow and H. V. Johnson.

After the minutes of the previous meeting were read and approved, the secretary read a letter from the executive secretary of the Kentucky State Medical Association in answer to the society's letter of protest to the raising of KSMA dues to $35.00 per year. The executive secretary wrote that J. Duffy Hancock, M.D., president of the KSMA, would be glad to discuss the matter with the society. It was moved and seconded that Dr. Hancock be invited to come before the society at the January meeting which will be held at noon on January 7, 1954.

Dr. Wells gave a report on the financial condition of the hospital and it was moved and seconded that the secretary be instructed to write to the Board of Trustees of the hospital and ask that the medical society be given a financial report of the hospital for 1953 and a copy of the auditor's report.

The Scott County Medical Society held an election of officers for 1954 with the following results: Dr. Lewis, president, Dr. Allphin, vice-president, Dr. Johnson, secretary and treasurer, Dr. Wells, delegate, Dr. Wilt, alternate delegate. Dr. Allphin was also elected to serve as Censor for three years.

H. V. Johnson, Secretary

The Scott County Medical Society met January 6, 1954, at the John Graves Ford Memorial Hospital in Georgetown. The following members were present: C. R. Lewis, M.D., E. C. Barlow, M.D., H. G. Wells, M.D., F. W. Wilt, M.D., W. S. Allphin, M.D., L. F. Heath, M.D., A. F. Smith, M.D., P. H. Crutchfield, M.D., and H. V. Johnson, M.D.

Guests of the society were J. Duffy Hancock, M.D., Louisville, president of the Kentucky State Medical Association and John Scott, M.D., Lexington.

Dr. Hancock addressed the society, explaining the necessity of increasing the dues from $25.00 to $35.00 per year, which the Scott County Medical Society has protested against. Dr. Hancock went over the different items and tried to show where the money was spent.

After his talk, Dr. Scott was called on and said the Kentucky State Medical Association, according to the constitution and by-laws, had no right to raise the dues without an amendment and thought that any man was entitled to membership by paying $25.00, the same as last year. A number of the local men also joined in the discussion after which the meeting adjourned until the first Thursday in February.

H. V. Johnson, M.D., Secretary

UNION

The Union County Medico-Dental Society met at Our Lady of Mercy Hospital on November 17, 1953. The minutes of the last meeting were read. A discussion of blastomycosis followed.

G. B. Carr, M.D., introduced the speaker, L. R. Mezera, M.D., Louisville, of the State Division of Maternal and Child Welfare. He discussed the maternal and child health field, noting that the picture is becoming serious in that infant mortality rates in Kentucky have increased and that Kentucky is second only to New Mexico in deaths. He gave reasons for this increase and some solutions for the problem.

He named the leading causes of death as prematurity, birth injuries and congenital malformations. He advised letting the public health nurse look over home situations and later report to the physician. He also discussed reporting diseases and touched on the need for health education.

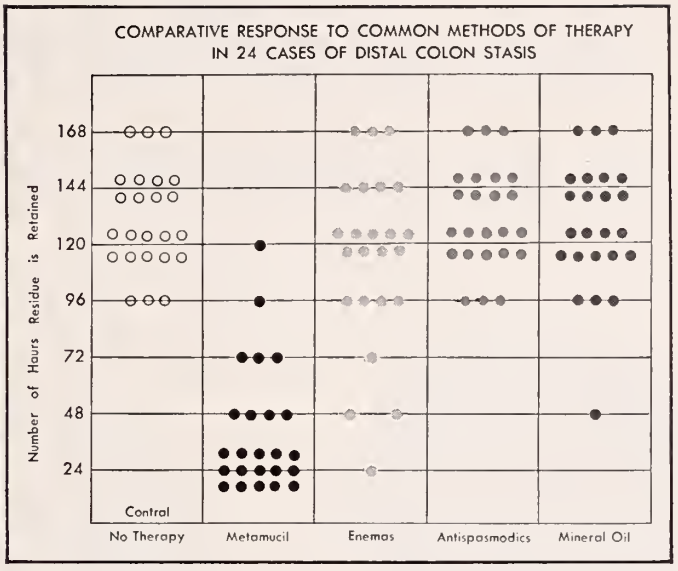
Charles P. Bartley, M.D., Secretary-Treasurer

The Union County Medico-Dental Society met for its regular monthly meeting December 15, 1953, at Our Lady of Mercy Hospital, G. B. Carr, M.D., president, presided. The secretary was instructed to answer the invitation of the Mobile Cancer Unit director and accept the offer of his visit to the society. W. P. Humphrev, M.D., gave a report as to the result of the Diabetic Survey Program.

(Continued on page 128)



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SEARLE *Research in the Service of Medicine*

*Barowsky, H.: A Roentgenographic Evaluation of the Common Measures Employed in the Treatment of Colonic Stasis. Rev. Gastroenterol. *19*:154 (Feb.) 1952.

(Continued from page 126)

The election of officers followed: George Welker, M.D., president, George Higgingson, D.D.S., vice-president, C. P. Bartley, M.D., secretary-treasurer, G. B. Carr, M.D., delegate, C. P. Bartley, M.D., alternate delegate.

Ros W. Harrison, of the Kentucky Blue Cross-Blue Shield, was the speaker. Highlights of his talk included history of the development of the plan, physician patient relationship with a discussion of fees and grievance committees, representatives in the field and prepaid plans. He also discussed new regulations of the Blue Cross-Blue Shield plan, with emphasis on physicians' service reports. Mr. Harrison encouraged the physicians to help prevent abuses whenever possible.

C. P. Bartley, M.D., Secretary-Treasurer

WARREN-EDMONSON

The regular meeting of the Warren-Edmonson County Medical Society was held December 8, 1953, at the Helm Hotel, with W. R. McCormack, M.D., presiding.

Dr. McCormack thanked the outgoing program committee for their excellent presentations during the year. He also mentioned the advisability of getting more publicity in the local and regional newspapers for the county medical society.

The basis for fees at the newly opened heart clinic at the hospital was discussed, and a committee composed of Doctors Pugh, Green and Moore are to study the problem and give a report at the next meeting.

The care of terminal cancer patients, especially those of the cancer clinic, was brought up by Henry S. Harris, M.D. It was decided that this subject be studied and reported on at the next meeting.

Daniel B. McIlvoy, M.D., who has headed the Nurse's Scholarship fund for the last year, reported that he had received $500 from the county medical society.

In an election of officers that followed, Richard O. Green, M.D., was elected president, Marcus B. Wilkes, M.D., vice-president, and Charles M. Francis, M.D., was re-elected secretary-treasurer.

Charles M. Francis, M.D., Secretary

News Items

V. A. Jackson, M.D., Clinton, was reported by the December issue of the Journal of the KSMA has having moved to Paris, Tennessee. Dr. Jackson has written the headquarters office that he has reconsidered and will remain in practice at Clinton.

J. G. Denhardt, Bowling Green, publisher of the Journal of the KSMA, was elected president of the Ogden College Alumni Association at the 26th Annual Banquet, which was held December 28, 1953, in Bowling Green. Among many projects, the association sponsors a fund set up to provide financial assistance to college students of Warren county. Ogden College merged with Western State College in 1928.

Spafford Ackerly, M.D., chairman of the Psychiatry Department at the University of Louisville, spoke at Duke University's 16th annual medical symposium, December 1, 1953. Dr. Ackerly addressed a group of physicians from the Carolinas, Virginia and Tennessee.

Wallace E. Herrell M.D., of the Lexington Clinic, discussed "Clinical Uses of Antibiotics" at the January 12th meeting of the Vanderburgh County Medical Society, Evansville, Indiana. Dr. Herrell, a 1933 graduate of the University of Virginia Department of Medicine, is the author of the book, "Penicillin and Other Antibiotic Agents," and has contributed material to more than 130 scientific publications.

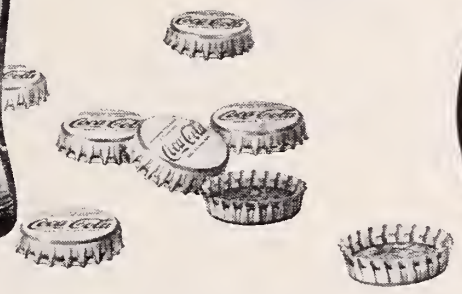
Evaline W. Plucknett, M.D., formerly of Tuckahoe, New York, recently located Eastern State Hospital, Lexington. Dr. Plucknett is a graduate of the University of California School of Medicine, 1948, and interned at Mercy Hospital, Des Moines, Iowa.

Charles P. Salyer, M.D., formerly of Burnside, has recently opened an office at 2815 Reid Street, Houston, Texas. Dr. Salyer, a 1945 graduate of the University of Louisville School of Medicine, interned at St. Elizabeth Hospital, Covington.

George Kimbrough, M.D., has returned to Louisville for additional medical training after finishing his internship at the United States Naval Hospital, Great Lakes, Illinois. He will serve a residency in internal medicine at Norton's Infirmary, Louisville. His wife, Laura Kimbrough, M.D., recently completed an internship at Evangelical Hospital, Chicago, Illinois. Both are graduates of the University of Louisville School of Medicine, 1948.



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In Memoriam

JAMES E. CRADDOCK, M.D.

Louisville

1907 - 1953

Dr. James E. Craddock, 46, died December 11, 1953, in Louisville as a result of burns he received in an accident. A native Kentuckian, Dr. Craddock was graduated from the University of Louisville School of Medicine in 1932. He served as a medical officer in the United States Navy during World War II and was an eye, ear, nose and throat specialist at the time of his death.

GEORGE S. COON, M.D.

Louisville

1866 - 1953

Dr. George S. Coon, 88, a veteran physician and surgeon of Louisville, died at his home, December 19, 1953. Dr. Coon remained active in the medical profession until the end of his life.

A native of Osage, Iowa, Dr. Coon was graduated from the Chicago Homeopathic Medical College in 1892 and started practicing in Louisville in 1894. He held membership in the Jefferson County Medical Society, the Kentucky State Medical Association, and the American College of Surgeons.

He had been a member of the Kentucky State Board of Health since 1919, was a member of the board of Waverly Hills Tuberculosis Sanatorium, and served on several Louisville hospital staffs.

DANIEL J. TRAVIS, M.D.

Eddyville

1873 - 1953

Dr. Daniel J. Travis, 80, died at his home in Eddyville, where he had practiced for 52 years. A native of Lyon county, Dr. Travis became a resident of Eddyville following his graduation from the University of Louisville School of Medicine in 1901.

For a number of years he served as physician at the Kentucky State Penitentiary and was connected with the Lyon County Health Department for 10 years before his resignation in 1951.

(Continued on page 132)

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IN MEMORIAM

(Continued from page 130)

Dr. Travis was a member of Lyon Chapter No. 61, Royal Arch Masons, and a member of the Board of Directors of the Eddyville Methodist Church. He was active throughout his life in his county society, and also held membership in the Kentucky State Medical Association and the American Medical Association.

ISAAC A. ARNOLD, M.D.

Louisville

1882 - 1953

Dr. Isaac A. Arnold died December 5, 1953, at Norton Memorial Infirmary, Louisville, where he was a former president of the medical staff. His medical career began with his graduation from the University of Louisville School of Medicine in 1907.

Following his service in World War I, Dr. Arnold was an instructor in surgery at the University of Louisville School of Medicine, later becoming clinical instructor in surgery.

Dr. Arnold held membership in the American Medical Association, the American College of Surgeons and the Kentucky State Medical Association.

ROBERT FULTON PORTER, M.D.

Middlesboro

1900 - 1953

Dr. Robert Fulton Porter, 53, died December 31, 1953, at his home in Middlesboro after an illness of several months.

A native of Caneyville, Dr. Porter was graduated from the University of Louisville School of Medicine in 1929 and began practice in Middlesboro in 1934.

He held membership in the Kentucky State Medical Association, the Southern Medical Association, the American Medical Association and the American Academy of General Practice.

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Pertinent Paragraphs

In Henderson, Kentucky, a project in eating for health, sponsored by the Citizens Health Committee, has captured the enthusiasm of the schools and community, according to James W. Armstrong, chairman. Two schools, the majority of whose pupils were found lacking in an adequate diet, became focal points for food testing. After 10 weeks of nutritious diets, teachers reported children had better attendance, higher grades and more attentive classroom participation, said Walter L. O'Nan, M.D., Henderson, also a member of the CHC.

Contributions to the American Medical Education Foundation during 1953 reached $1,047,000, with more than 24,500 physicians donating $847,361 directly to 70 of the nation's 79 approved medical schools. Plans for the 1954 campaign were discussed at the third annual meeting of AMEF state chairmen January 24, in Chicago.

A survey to determine the underlying attitudes of physicians toward voluntary health insurance is currently being sponsored by the AMA's Council on Medical Service, through its Committee on Pre-payment Medical and Hospital Service. The survey is designed to bring to light existing attitudes toward service benefits, coinsurance and fee schedules, important factors to consider in the future planning of insurance programs.

New plans for radio and television programs have been announced by the AMA's Bureau of Health Education. Inaugurating a new service for state and county medical societies, the Bureau is preparing "script-clip packages" for television. These packages will contain outline scripts which can be narrated by local physicians while film clips illustrating the topic are shown on the TV screen.

A limited number of teaching resident fellowships are being offered by the American Trudeau Society, Medical Section of the National Tuberculosis Association, to promote the training of clinicians, medical teachers and administrators in the field of tuberculosis and related pulmonary diseases. Preference is given to candidates not more than 30 years of age possessing a Doctor of Medicine degree, all of whom must be citizens of the United States and

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agree to work in this country. Further particulars concerning these fellowships may be obtained on request from your KSMA Headquarters office.

A one-year gift subscription to "Today's Health" was recently presented to each of the forty 4-H Club achievement winners throughout Wisconsin by the state medical society. For many years, the society has given engraved certificates to these winners, but this time felt that the inauguration of this new project would be more beneficial in its rural health education program.

The Sixth Annual Convention of the International Academy of Proctology will be held at the Palmer House, Chicago, Illinois, April 8-11, 1954. Much of the program has been planned to answer the questions of general practitioners, who face proctologic problems in their daily practice. There will be no fee for attendance at the Annual Convention. The program will be available in the near future, upon request to the Executive Office of the International Academy of Proctology, 43-55 Kissena Boulevard, Flushing, New York.

By special invitation of the museum, the American Medical Association will display its exhibit, "The Organs of Human Body," at the Smithsonian Institute in Washington, D. C., during 1954. After this year, the exhibit will be available for showings in other museums throughout the country.

A new exhibit, "The Physician's Responsibility in Highway Accidents," may be booked for professional showings only through the AMA's Bureau of Exhibits. It is designed to call the physician's attention to the fact that he should warn patients about the dangers of driving while under the influence of sedatives, antihistamines or anticonvulsive drugs.

Steven M. Spencer, a medical science writer for the Saturday Evening Post, recently finished a book covering dramatic events of medical progress from 1940 to 1950, according to George F. Lull, M.D., secretary and general manager of the AMA. Dr. Lull describes the book, published by McGraw-Hill, as representing "medical reporting at its best, blending the disappointments and triumphs that have marked mid-century progress."

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Operating Room in Hospital...	10.00	20.00	30.00	40.00
Anesthetic in Hospital.....	10.00	20.00	30.00	40.00
X-Ray in Hospital.....	10.00	20.00	30.00	40.00
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The sixth meeting of the International Cancer Congress will be held in Sao Paulo, Brazil, July 23-29, 1954, reports the American Cancer Society. The scientific program will be divided into four classifications: biology and investigation, pathology, radio and surgical treatment and social fight. Complete information on transportation, hotel arrangements and the program can be obtained at the KSMA headquarters office.

Daniel A. Reed (R., N.Y.) of the House Ways and Means Committee, has indicated that he does not favor use of compulsion by Congress in attempting to bring self-employed groups such as physicians under social security coverage, reports the AMA Washington office. Mr. Reed's committee is holding public hearings in 1954 on the administration's proposal, introduced in August, 1953, which would extend Old Age and Survivors Insurance to about 10,500,000 more persons.

"Malignant neoplasms of bone represent one of the most important causes of death in children," reports John F. Holt, M.D., University of Michigan Department of Roentgenology, in the November issue of "Radiology."

WASHINGTON NEWS DIGEST

(Continued from page 123)

The American Medical Association agrees with the Defense Department that all dependents should receive medical benefits as nearly uniform as possible. However, AMA contends that wherever possible dependents should use private physicians and private hospitals, and that the military personnel and facilities should be employed only where civilian facilities are inadequate.

INDUSTRIAL HEALTH CONGRESS

(Continued from page 118)

will round out the afternoon meeting, February 25. The program will cover atomic, bacterial, chemical and psychological warfare, and include a preparation program in operation in Vicksburg, Mississippi.

A preliminary conference with chairmen of state medical society committees on industrial health will be held on February 23. One of the subjects to be covered will be what American medicine should strive for in its relations with labor and management. Group conferences on topics relating to industrial health will also be held.

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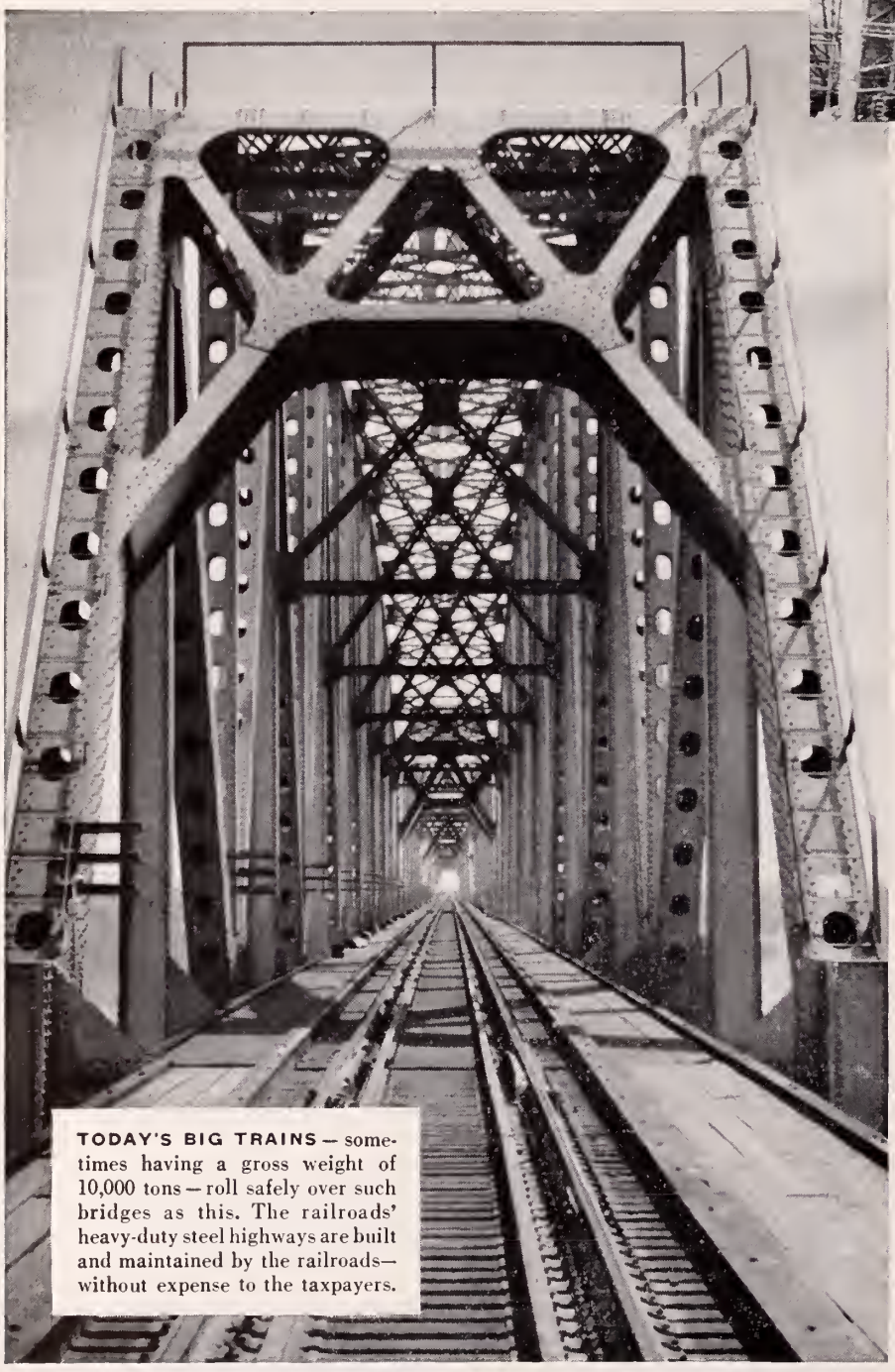
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1. Werner, A.: Acta endocrinol. *13*:87, 1953.
2. Malleson, J.: Lancet *2*:158 (July 25) 1953.
3. Goldzieher, M. A., and Goldzieher, J. W.: Endocrine Treatment in General Practice, New York, Springer Publishing Company, Inc., 1953, p. 23.

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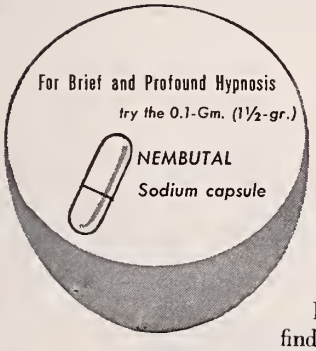
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---

1. McLester, J. S., and Darby, W. J.: Nutrition and Diet in Health and Disease, ed. 6, Philadelphia, W. B. Saunders Company, 1952, pp. 287-299.

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1. Kauntze, R., and Trounce, J.: Treatment of Arterial Hypertension with Veriloid (Veratrum Viride), Lancet 2:1002 (Dec. 1) 1951.
2. Wilkins, R.W.: Combination of Drugs in the Treatment of Essential Hypertension, Mississippi Doctor *30*:359 (Apr.) 1953.

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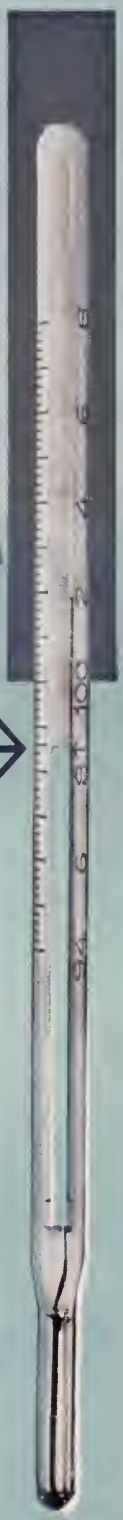
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1. English, A. R.; P'an, S. Y.; McBride, T. J.; Gardocki, J. F.; Van Halsema, G., and Wright, W. A.: Antibiotics Annual (1953-1954), New York, Medical Encyclopedia, Inc., 1953, p. 70.
2. Finland, M.: Brit. M. J. 2:4846 (Nov. 21) 1953.

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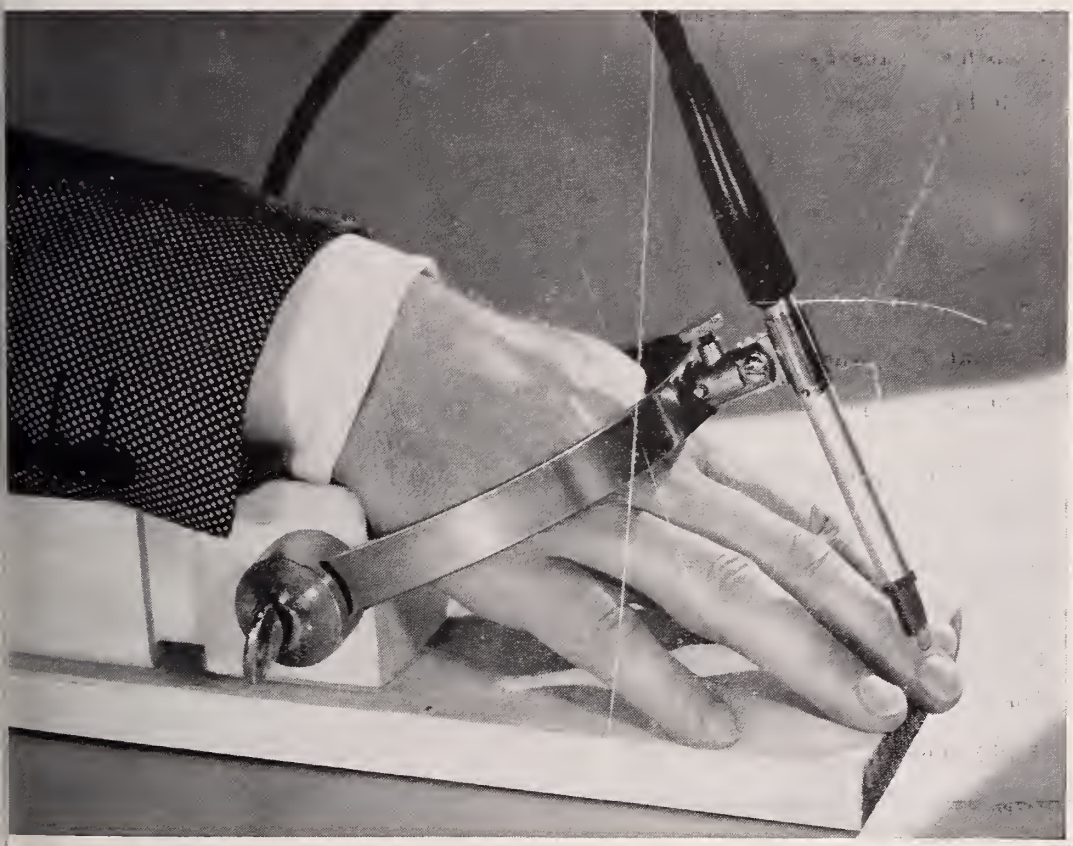
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For these reasons, smokers have made the new KENT the most popular new brand of cigarette to be introduced in the last 20 years.

If you have yet to try the new KENT with the exclusive Micronite Filter, may we suggest you do so soon?



WHEN SYMPTOMS ARE DISTRESSING BUT DISGUISED . . .

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Changes in the mood pattern are just a few of the many distressing symptoms of declining ovarian function which are so often disguised because they do not always coincide with cessation of menstruation, and at times will occur long before, and even years after. Other good examples are insomnia, headache, easy fatigability, arthralgia — and understandably so, when one considers that the loss of ovarian hormone "withdraws one of the most important metabolic regulators of the organism."[2]

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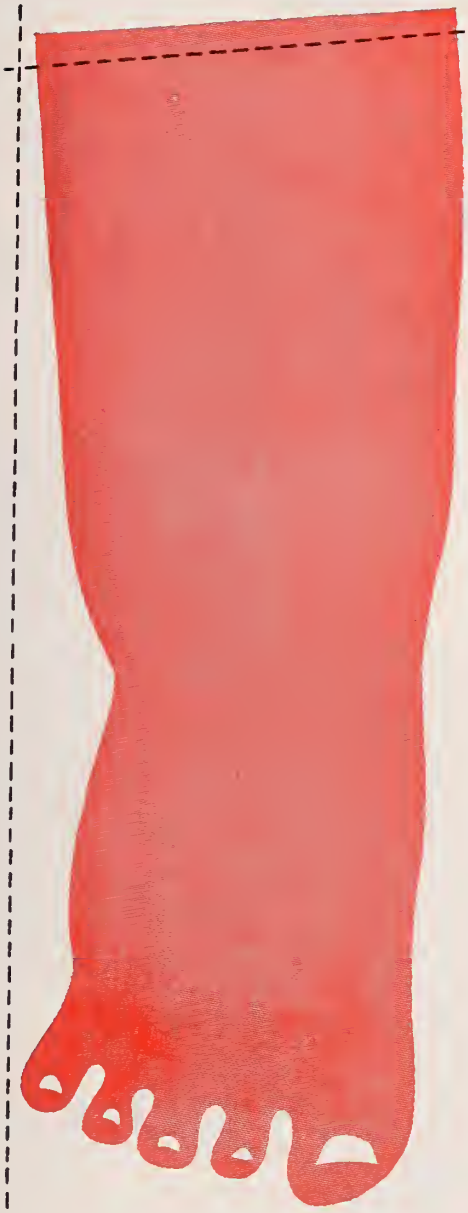
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1. Malleson, J.: Lancet 2:158 (July 25) 1953. 2. Goldzieher, M. A., and Goldzieher, J. W.: Endocrine Treatment in General Practice, New York, Springer Publishing Company, Inc. 1953, p. 23.

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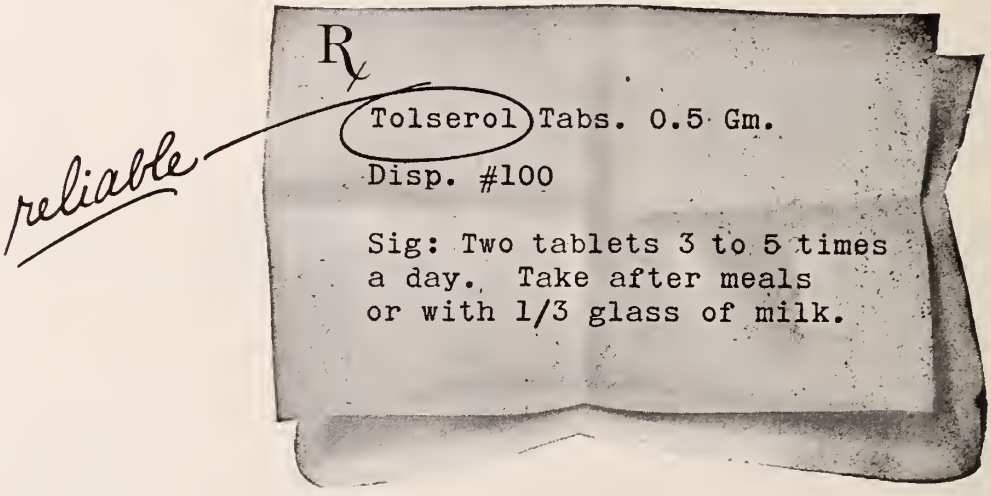
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Overcoming the Pitfalls in the Differential Diagnosis of Jaundice

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The multiplicity of functions of the liver, combined with the great reserve inherent in that organ, tend to make differential diagnosis of hepatic disease a very difficult problem indeed. Biochemists and physiologists working in their laboratories seem to have become obsessed with the idea of devising a host of liver function tests, which usually reflect only a single special function or physiological action of the liver. Clinicians in turn seem to become infatuated with these techniques for measuring the functions of the liver, and so, upon being confronted with a case of jaundice, they are so enamored with the interpretation of the function tests which have been run, that frequently they tend to overlook the organism with which they are working. And great indeed is their disappointment when they are forced to admit yet once again, that it is the rare case of jaundice which represents pure obstruction or pure hepatic cell disease, but that most cases represent a blending of the two and so the results of their testing are equivocal, if indeed the proper tests have been run in the first place. But enamored as they are with an idea, they continue to turn again and again to the same fickle tests which have let them down in the past.

If this paper has a function, perhaps it is to impress again the fact that laboratory studies are not the means of making a diagnosis of jaundice, but rather are a means of confirming or rejecting a working clinical diagnosis.

It might be well to preface any remarks regarding the technics of differential diagnosis by stating that jaundice rarely if every constitutes a medical emergency. Usually the course of these patients may run safely over a period of many days or even weeks before any specific action must be taken, and consequently there is adequate time available to study the patient well from all points of view.

It has been stated that perhaps the chief value of liver function tests is that they take time during which period the etiology of the jaundice may become apparent. Certainly less harm is done the patient through erroneously delaying surgical exploration in the face of mechanical obstruction, than would result from ill-advised surgical intervention in patients with parenchymal lesions, wherein changes secondary to anesthesia and surgery added to the liver showing previous injury may prove fatal or lead to chronic liver disease.

In attempting to assess the reasons for failure in arriving at a definite diagnosis of jaundice, it seems to me that several failings on the part of physicians may be responsible. The first factor is the inclination which many clinicians have, to attempt to make a specific etiological diagnosis without first categorizing the jaundice as to type. The separation of cases of jaundice according to their type is the first step in differential diagnosis and from a practical point of view may be the only thing that is necessary, inasmuch as therapy is the same in each group regardless of cause. So far as the handling of the patient goes, specific etiological diagnosis serves no useful function, other than perhaps in determining the prognosis. Whether intra-hepatic jaundice is due to hepatitis, cirrhosis, cholangiitis or other inflammatory conditions makes little difference inasmuch as the immediate approach to therapy is medical in all. Similarly, whether obstruction is due to com-

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mon duct stone, carcinoma of the ampulla or of the head of the pancreas, the immediate aproach is surgical in nature and the differentiation serves only as an academic exercise.

Classification

A good and simple working classification divides cases of jaundice into three groups, depending upon whether the pathology causing the jaundice lies in the organism generally, within the liver itself, or in the bile passages after they leave the liver, and are known respectively as the pre-hepatic, hepatic, and post-hepatic types.

The pre-hepatic type of jaundice, also known as hemolytic jaundice, results from an overproduction of bile pigments secondary to the excessive destruction of red blood cells by the reticulo-endothelial system throughout the body. The nature of this excessive destruction is a problem unto itself not within the scope of this presentation.

There are certain rather constant features of pre-hepatic jaundice which make it readily recognized and ordinarily it presents relatively little if any problem in differential diagnosis. The major cause for failure to diagnose cases of this group is due to failure to keep it in mind. Inasmuch as the liver and biliary system are not involved in this type of illness, liver function tests will give perfectly normal results and at the same time studies of bile pigment excretion will likewise present normal findings.

Since this jaundice is due to excessive destruction of red cells, anemia of some degree must necessarily develop. The pigments so released from the destroyed red cells are still bound into a protein complex and consequently fail to pass the renal barrier so that no bile appears in the urine giving the synonym, acholuric jaundice. By the same token, the VandenBerg test gives an indirect reaction.

In our discussion, we will talk about the separation of the hepatic and post-hepatic types only.

The hepatic type of jaundice is due to disease or injury involving liver cells themselves, and includes hepatitis and cirrhosis as the two major examples.

The post-hepatic type of jaundice refers to involvement of the biliary passages after they leave the liver. This group of cases is always obstructive in nature, and is referred to as surgical jaundice.

The second cause for failure in arriving at a definite diagnosis of the cause of jaundice is turning immediately to the laboratory for help before a working clinical impression has been reached. The result is consequent confusion when equivocal laboratory reports are obtained inasmuch as all interpretations must be made on the basis of the working diagnosis. Practically every discussion concerning the differential diagnosis of jaundice lists the various tests of liver function, discusses them in straight-forward fashion and generally implies that the results and interpretations are fairly simple and clear-cut. As a matter of fact, frequently these tests are presented in tabular form as if the results in every case of jaundice point sharply to whether it is hepatic or post-hepatic in type. However, several sources of error exist which should be taken into consideration at all times. These causes for confusion usually result from three well defined situations wherein considerable overlapping of the boundaries which are usually drawn between medical and surgical jaundice occur. These are intra-hepatic obstruction in cases of hepatic jaundice; secondary biliary hepatitis due to prolonged obstruction and back pressure occurring in cases of post-hepatic jaundice; and finally, ascending purulent infection involving the portal areas in the liver.

Various Causes of Obstruction

During the course of any inflammatory disease of the liver, the flow of bile into the duodenum may be completely obstructed for various lengths of time although no mechanical obstruction can be demonstrated anywhere within the extra-hepatic system. Though the basis for this obstruction is not clear, it is probable that inflammatory processes in the portal fields may lead to compression of the small terminal bile canaliculi. Other features, including the inflammatory reaction around the bile ducts in the portal area, or the lobular disarray which may serve to amputate small ducts are other possible means by which such a situation may come about. However, obstruction is still obstruction regardless of where it occurs or the means by which it occurs, whether the obstruction is due to common duct stone or due to intra-hepatic block; whether in the extra-hepatic biliary system in so-called surgical jaundice, or in the liver in so-called medical jaundice, and consequently the laboratory results will be the same.

The reverse of the preceding situation is found in extra-hepatic obstruction of the biliary passages where as a result of retention of irritating or injurious bile products within the liver cells and bile capillaries, a secondary liver cell damage occurs, giving rise to a so-called biliary hepatitis which so far as laboratory data goes is indistinguishable from any other type of hepatitis. The length of time which is required for this amount of liver function damage to occur varies considerably, but with complete obstruction it is usually present within two weeks, and is marked by four weeks. At this time the damage is uniform and sufficiently well developed to completely simulate, from the point of view of function tests, a hepatic type of jaundice. Closely related to this is the so-called purulent ascending intra-hepatic cholangiitis. Here again, though the original pathology is due to mechanical obstruction and consequently would place the patient in a group of surgical jaundice, the results of laboratory data largely might be of hepatic cell damage, and thus incorrectly indicate a medical jaundice.

The development of findings of hepatic damage after prolonged obstruction is generally well considered, but the finding of obstruction in cases of hepatic disease is considered much less generally.

The third factor to be considered in failure to make an effective differential diagnosis of jaundice is failure to have sufficient faith and confidence in one's original clinical impression to depend upon it and stick to it, unless of course subsequent observations on the patient point out the fact that the original impression was inconsistent with the course. Perhaps much of this is due to the fact that the original diagnosis was made on equivocal grounds. However, there is a certain tendency on the part of physicians, after making the original diagnosis of a type of jaundice to become panicky or disturbed when the course of the jaundice is somewhat longer or different than anticipated originally.

It is frequently said that the jaundice of hepatic disease is short, rarely lasting more than two or three weeks, whereas the duration of jaundice in post-hepatic cases may be longer. I doubt if this factor is of any real consideration in any given case. Many cases of hepatic jaundice may go on with a picture of complete obstruction extending over a period of many weeks or even months, whereas on the other hand obstructions due to stones may fluctuate frequently and even the jaundice of carcinoma of the ampulla may fluctuate or even be relieved by ulceration and sloughing of the lesion.

With these short-comings of the clinician and sources of error in the interpretation of laboratory data well fixed in mind, we can turn our attention to the differential diagnosis of the jaundiced patient.

Differential Diagnosis

The problem of the differential diagnosis of jaundice is to be approached in the same manner as the differential diagnosis of any other condition. And that of course means starting with the history and physical examination. In this present era of biochemical assay, there is a growing tendency to reduce most diagnostic problems to the performance of a battery of tests, but nowhere is this more to be decried than in the diagnosis of jaundice. In 1845, writing on diseases of the liver, George Budd said, "Jaundice is rather a symptom of disease than disease itself, and may arise from various causes which it is very important that we should be acquainted with; because a knowledge of the cause often gives us an insight into its real nature, which we could scarcely obtain from considering the symptoms merely."

I am sure that none of us give enough value to this phase of the differential diagnosis, a value brought out by the close correlation of the original clinical impression derived by this means with the histology shown by biopsy or autopsy. Various authors have reported figures as high as 84% correct on this basis alone, and few report a correlation lower than 66%. As a matter of fact, this correlation on the basis of clinical impression alone, is much higher statistically than that obtained from laboratory data alone, without clinical impression. Any practitioner who will take a careful history, make a complete physical examination, and then perform only a minimum of relatively simple laboratory procedures, should be able to arrive at a correct working diagnosis in about 90% of all cases, by which I mean, categorizing the jaundice properly as to type, and with definite impression as to cause.

The family physician first seeing the patient with jaundice has several advantages

over later physicians seeing the same patient in that he knows the patient, his background and family history, and can better evaluate the history of onset and severity of symptoms. He is also in a position to see the disease in its early uncomplicated form, and thus is best able to get unequivocal results on history, physical examination, and laboratory data.

The History

So far as the general points in the history go, age is of some importance, in that most jaundice seen in the younger age groups will be of the hepato-cellular type or occasionally of the hemolytic variety. Obstructive jaundice due either to stone or to neoplasm, is relatively uncommon before the age of 40. This point alone may serve to direct your major thinking into the proper channel.

Sex likewise is of help in directing your thinking, in that jaundice due to cholecystic disease or stone is much more common in the female, a ratio of nearly 5:1, whereas jaundice due either to cirrhosis or neoplastic obstruction either in the liver or the head of the pancreas is more frequent in the male. Obstructive jaundice, regardless of specific cause, is to 2 to 4 times more frequent in men.

While still reviewing the background of the patient, knowledge of the occupation of the patient may be of aid. Toxic hepatitis from drug or chemical exposure may be a factor, and it is not only the worker in industry who is liable to this. Housewives may decide to clean furniture or clothing with carbon tetrachloride, or mechanics or other technicians may use it or other toxic solvents to clean machinery parts. Likewise consideration of less common causes of jaundice such as Weil's disease, may be stimulated if the patient is a butcher, sewer worker, plumber, etc., who may come in contact with the vector of this disease.

Closely related to occupational exposures to hepatotoxic drugs, is the exposure to drugs or chemicals which might be used medicinally. Since the use of cinchophen is no longer common, this cause of jaundice is no longer very important, but should ever be kept in mind. Certainly the two most important exposures which should be sought for, are alcohol, and blood or blood products, the latter including even simple needle puncture.

A history of blood transfusion, plasma, or other injections within a period of six weeks to six months preceding the onset of jaundice is of such diagnostic significance, that it might well outweigh all other combined data in any given case. Perhaps the major exception to this rule is those patients who are seen subsequent to recent gall bladder or biliary tract surgery where consideration must be given to mechanical obstruction because these patients may develop strictures, especially if their course was stormy or if there was considerable biliary drainage; approximately 10% have stones missed during common duct exploration which later may give transient obstructive signs; or small cancers overlooked during the laparotomy may become symptomatic.

Homologous serum jaundice is being seen with greater frequency from year to year and certainly with the widespread use of blood and blood products, its frequency should continue to increase. Because transmission may occur with minute amounts of serum, 0.01 ml., and because the virus is very resistant, the use of inadequately sterilized needles, syringes and stylets may act as vectors and the responsibility of the physician in its transmission is a major one.

Alcohol is a point of considerable debate, but certainly in a patient who gives a history of large alcoholic intake, particularly at the expense of normal dietary intake, the possibility of acute fatty metamorphosis of the liver, or later cirrhosis, becomes considerable. A history of alcoholism is present in 75% of such cases. In following up the past history further, certainly any history of surgery for cancer anywhere in the body must be viewed with more than suspicion and carcinomatosis in the face of such a history must be carefully excluded before any other diagnosis can be established.

One may also learn that the patient has had recurrent bouts of jaundice and that also some other members of the family have had recurrent jaundice. This point alone would seem to indicate the presence of familial hemolytic icterus. Along the same line, a history of a sibling requiring cholecystectomy for stones at a very early age likewise points to the same diagnosis, inasmuch as these patients inevitably form small pigment stones. Conversely, a history of acute jaundice within the past six months in neighbor, friend, or family points toward viral infectious hepatitis as a probable choice.

A final point in reviewing the past his-

tory of the patient, is a background of chronic dyspepsia, flatulence and intolerance to fatty foods. This is familiar background in patients having cholecystic disease, and this point alone may be sufficient to lead one to a diagnosis of obstructing stone. Needless to say, a past history of typical biliary colic, with chills, fever and recurrent jaundice likewise indicates obstructing stone.

Details of Presenting Illness

Going into the details of the presenting illness, certainly the type of onset is of considerable importance. The jaundice associated with cholecystitis and common duct stone usually presents a stormy explosive type of onset. On the other hand, the development of chronic hepatic disorders and extra-hepatic block due to neoplasm usually presents a slow insidious type of onset which is difficult to recognize. Acute infectious hepatitis usually is characterized by general influenza-like complaints early, with marked anorexia and nausea being common initial symptoms.

The pain described by the jaundiced patient may be of considerable help. If characteristic sharp pain such as is found with common duct stone is present there is little confusion about it. On the other hand, the pain most usually associated with primary hepatic disease is described as a feeling of heaviness or vague discomfort in the right upper quadrant, and sometimes there is a dragging sensation in this region. Very occasionally more severe types of pain may be present with infectious hepatitis. Patients with pancreatic cancer have long been described as having a painless type of jaundice, but most of these patients do complain of nagging or gnawing epigastric pain which not infrequently radiates off to the left and to the back. If to this type of pain is added the history of considerable weight loss and jaundice, the diagnosis of pancreatic cancer becomes fairly well elucidated. In general then, a stormy febrile onset with real pain generally points to a surgical condition, while on the other hand the absence of pain or vague discomfort may be of little or no assistance in the differential diagnosis.

The course of the illness is of relatively little help unless there is considerable variation in the degree of jaundice, and concurrently in the amount of bile pigment appearing in the stools. This situation is usually associated with obstruction of the common duct by stone. Occasionally rapid fluctuations in the degree of icterus, if associated with tarry stools, may indicate carcinoma of the ampulla of Vater which has ulcerated with bleeding, and at the same time temporarily opening the outflow of bile. The length of time which the patient has been ill has some diagnostic value, though the duration of jaundice alone is not a very valid point. Though most patients having hepatic types of jaundice usually show improvement within the matter of three or four weeks, exceptions to this occur often enough to invalidate this point in one's consideration.

Physical Examination

In any discussion of the physical factors which may be of value in the differential diagnosis of jaundice, it may seem needless to state that a careful general physical examination is in order first of all. On such an examination other findings may be discovered such as generalized lymphadenopathy, the presence of tumors elsewhere in the body, evidence of vitamin deficiency, loss of axillary hair, testicular atrophy, etc., which may serve to indicate the nature of an underlying disease process.

Physical examination frequently does not contribute very much to the differential diagnosis of jaundice, but certain signs when present may be of very great assistance. Regarding the size of the liver, not too much reliance can be placed upon this, although certain generalities may be established. Extremely large livers, down to the umbilicus or below, are usually the result either of carcinomatosis or of marked fatty metamorphosis. The latter can be followed up further by the history of alcoholism or dietary inadequacy. A considerable point is made regarding nodularity of the liver as indicative of carcinomatosis but this finding is not too consistent. Schiff, reporting a large series of liver biopsies in patients with carcinomatosis, reported equal incidence of neoplasm in livers whether they were nodular or smooth.

Obstruction, if high in degree, likewise gives an enlarged liver but in these cases the enlargement is perhaps two or three cm. in degree. Infectious hepatitis and other types of hepato-cellular jaundice give marked variations in liver size and this serves as a useful point in these cases

if it is followed along. The enlargement of the liver must likewise be correlated and referred to the duration of jaundice. If present at the onset of jaundice or if noticed even in the pre-icteric phase, the probability of parenchymal disease certainly must be considered. Progressive enlargement of the liver late in the course of jaundice usually is secondary to extra-hepatic biliary obstruction.

Splenomegaly usually indicates that the jaundice is pre-hepatic or hepatic in origin. In the first place, splenomegaly is almost always associated with a great variety of hemolytic states and here the other findings are usually definite enough to clarify the problem. Hepatitis, cirrhosis, or even neoplasm may give rise to splenomegaly. In general one might say that splenomegaly rules out surgically correctible obstruction as a cause of jaundice in any case.

When the common duct is obstructed, the increasing pressure of accumulating bile will gradually distend the gall bladder if it has not been thickened by previous inflammation such as might occur in chronic cholecystitis. This is the background of Courvoisier's Law. Approximately 50% of patients with cancerous obstruction will present an enlarged gall bladder to clinical examination if it is carefully sought for. On the other hand, only 10% of patients with obstruction due to stone show this finding.

Because of the obstruction to portal flow which occurs in jaundiced patients due to hepatic causes and particularly cirrhosis, evidence of collateral venous circulation may be present. This may take the form of visible veins over the abdomen, a caput Medusa, esophageal varices as shown on X-ray visualization, or large rectal hemorrhoids. Ascites is ordinarily associated with hepatic jaundice, though carcinomatosis may also cause a similar picture. However, carcinomatosis sufficient to cause both jaundice and ascites can probably be recognized as part of a widespread occurrence. Additional physical findings include arterial spider angiomas, which are found in patients with hepatic jaundice, usually of long standing as cirrhosis, and the closely related palmar erythema which has the same significance.

Laboratory Aids

In turning to the laboratory aids which may be of value in the differential diagnosis of jaundice immediate problems are presented by the fact that most hepatic diseases are composed of several basic pathological processes each of which influences the results of function tests in a different way. As has already been pointed out, the major cause for confusion in interpretation of laboratory data is that interference in the flow of bile after its formation by the liver cells may occur either as the result of extra-hepatic or intra-hepatic factors, and laboratory tests do not differentiate between the two, nor do they indicate the type of hepatic damage due to prolonged obstruction.

Though a great battery of laboratory tests are available to the clinician in studying a case of jaundice, and in spite of the fact that in many centers a broad profile of liver function studies is routinely carried out, there are only a few groups of tests of any value in differential diagnosis. Certainly many of the other tests available may test specific liver functions, but none are dependable in this differential consideration. The laboratory procedures which I feel are of value are four in number; 1. Studies of bile pigments early in the course of the disease; 2. Flocculation tests; 3. Alkaline phosphatase determination; 4. Response of prothrombin-time to Vitamin K.

Obstruction is the same thing no matter where it occurs, in the liver or in the post-hepatic structures and consequently the laboratory will give practically identical results in both types. As a matter of fact, the presence of jaundice alone indicates that the ability of the liver to excrete is impaired or obstructed and consequently we can disregard all the liver function tests of an excretory nature as any help in differentiating the location of the block. The mere running of these tests on patients who are deeply jaundiced constitutes a hazard and a waste of time, effort, and expense. Among these tests are Bromsulphthalein, gall bladder visualization, Calcium, Cholesterol, Fatty Acids, Rose Bengal, Bile pigments, etc.

Interpretation of bile pigment studies is fraught with considerable difficulty, inasmuch as the general history of the illness affects them considerably. In the first place, presence of bile in the urine merely tends to rule out the pre-hepatic group of cases, but offers no differentiation between hepatic and post-hepatic cases. Lack of bile in the stool is merely the expression of obstruction to bile flow, and since

this is common again to all cases of hepatic and post-hepatic jaundice, it would have little useful value. Careful quantitative chemical determinations have been proposed as being of help in separating various types of obstruction, but I feel there is little to be gained from these studies which would offset the difficulty both in obtaining proper specimens and in running the determinations.

Urobilinogen in the urine which is due to a failure of the liver cells to normally reoxidize urobilinogen to bilirubin, may be of some value if measured within the first week of illness. However, after that time, decreased amounts of bile entering the bowel may be the cause of unusually low levels of urinary urobilinogen in cases of hepatic jaundice whereas on the other hand the damage to the liver cells from back pressure may provide the means for obtaining abnormally high values in post-hepatic jaundice. Another point of confusion to be kept in mind is that urobilinogen levels may be unusually high in cases of pre-hepatic jaundice due to increased amounts of bile pigment being excreted.

Studies of the bile pigments in the blood provide little differential value, even using the quantitative differential bilirubin determination, that is, separating the one minute direct bilirubin from the remainder of the direct and indirect fractions. This test is so frequently in error that I feel it adds more confusion than help.

Changes in Serum Protein

Regarding the large number of tests which are related to changes in the serum proteins, one might generalize and say they point up qualitative changes in the composition and stability of the blood serum and have as their advantage a simplicity of analysis which offsets what they may lack in quantitative accuracy. Although the mechanisms involved in the production of individual tests vary, all have certain features in common which include: a reduction in the serum albumin; a change in the ability of the albumin to inhibit the flocculation of colloids by gamma-globulin; an increase in gamma-globulin which has a flocculating effect; and finally an increase in lipoprotein. Tests in this group include the Cephalin-cholesterol flocculation test of Hanger, the Colloidal Gold and Congo Red reactions, the Thymol Turbidity Test, the Zinc Sulphate Turbidity Test of Kunkel and others. Though these tests interpret or mirror alterations in hepatic cell metabolism, it is apparent at once that in illnesses primarily inflammatory in nature and involving the reticulo-endothelial system, these tests would show more profound alterations, inasmuch as that is the site of gamma-globulin production. An example of this might be infectious mononucleosis, in which disturbances of the reticulo-endothelial system may frequently give a positive flocculation test with little measurable alteration in other liver functions. On the other hand, with changes in the liver due to carbon tetrachloride intoxication, profound disturbances in liver functions even with intense jaundice may occur, and still show little or no disturbance in the reticulo-endothelial function of the liver as indicated by these blood protein studies.

From a clinical point of view these tests do have a definite function, though it is somewhat of a negative nature. A negative test occurring very early, or else late in the course of jaundice, in most cases rules out the possibility of hepatic jaundice. Even when considerable biliary hepatitis is present these tests may remain negative, which is attributed to a blocking of the normal activity of the Kupffer cells by the irritating bile pigment which they have taken up. Conversely a strongly positive test early in the course of jaundice, pretty well indicates the jaundice as being hepatic in origin.

When taken in association with other findings as we will see below, this group of tests may take on added significance.

Alkaline phosphatase is the third test of value in the differential diagnosis between hepatic and post-hepatic types of jaundice. Phosphatase apparently is localized particularly in the cells lining the bile canaliculi, while the parenchymal cells of the liver are nearly devoid of phosphatase. Consequently, any disease process affecting the parenchymal cells primarily would not be expected to produce any alteration in the phosphatase level. On the other hand, in obstructive jaundice, the bile canaliculi are dilated and at the same time either stimulation or regeneration of the cholangiolar epithelium causes the total phosphatase activity to be increased.

The possible sources of error in this test lie in the presence of coexisting skeletal disease such as Paget's disease, or the presence of cholangiolitic hepatitis, wherein as a result of intra-hepatic block and

marked proliferation of bile radicals, some elevation may occur. Levels of alkaline phosphatase activity higher than 10 or 12 Bodansky units particularly in the face of mild or moderate degrees of icterus, must necessarily indicate obstructive disease.

Maintenance of a normal prothrombin level is one of the functions of the liver, provided it is first supplied with an adequate amount of vitamin K from the intestine. Obstructive jaundice lowers the prothrombin level by interfering with intestinal absorption of vitamin K due to lack of bile salts necessary for proper absorption. Inasmuch as the hepatic cells continue to function normally, this type of deficiency is quickly corrected by the parenteral administration of vitamin K. The amount given seems to make little difference in the degree of response, 1 mgm. or massive doses apparently giving very similar results. On the other hand, in cases of hepatic jaundice in which the hypoprothrombinemia is due to inability of the liver to form prothrombin, administration of vitamin K produces little or no change. Since both the hepatic and post-hepatic types of jaundice produce similar prolongation of the prothrombin time although they do so by different means, this test is of great value in the differential diagnosis between the two.

Combining the results of these tests and considering them in combinations, gives information of much greater significance. For example, in the presence of mild to moderate degrees of jaundice, the presence of strongly positive flocculation tests takes on added value in indicating hepatic jaundice. If combined with the finding of a normal phosphatase level it becomes even more significant. On the other hand, with high levels of icterus, the finding of a negative flocculation test with a high level of phosphatase would indicate a post-hepatic type.

Certainly there are many other tests of great value to be used in the study of hepatic disease, and the limited number of tests listed here by no means diminishes their value. On the other hand, the purpose of this listing is to select a minimum number of tests of real functional value in differential diagnosis, as a protest against great amounts of laboratory data, often unnecessary, frequently overlapping, and not unusually poorly chosen for the problem to be solved.

Liver Biopsy

However, after all the diagnostic work has been carried out, there still remains a group of cases, approximately 20% of the total, in which all diagnostic technic, history, physical examination and laboratory data, fails to elucidate the proper category of jaundice. In this group of cases, aspiration biopsy of the liver is perhaps the most effective means of catagorizing the jaundice both as to type and etiology, and at the same time allows a specific etiological diagnosis to be accurately and positively determined.

As matters stand now, this test can be carried out as a bedside procedure and offers little in the way of discomfort or risk to the patient, if carefully done by someone who is experienced and competent in its use. The procedure has certain risks to be sure, most of which revolve about abnormal bleeding tendencies which may be present in jaundiced patients, and the possibility of bile leakage from the biopsy site. However, by careful selection and with good technic, these risks are certainly minimized.

Most composite figures from a variety of reports show that liver biopsy is decisive in making the differentiation in at least 90% or more of the patients with jaundice, and possibly while not helpful in a few cases, is at variance with the situation which exists only in a very small number of patients. This is in extreme contrast to the results of biochemical studies alone in which the degree of accuracy is in the range of less than 60%.

In addition to this differentiation, biopsy provides the only means I know to definitely make a diagnosis of carcinoma, whether it be primary or metastatic, and to establish a specific etiological diagnosis in obscure illnesses.

As with biochemical tests, the earlier in the course of the illness that needle biopsy can be carried out, the more specific are the changes noted and the more exact a diagnosis which can be rendered. Certainly if obstruction has been present over a long period of time, secondary cholangiolitic inflammatory changes within the liver may give rise to some confusion.

Summary

1. Failure to make a proper differential diagnosis of jaundice is frequently the result of these shortcomings on the part of

the physician: the inclination to make an etiological diagnosis immediately rather than to categorize the jaundice as to type; turning to the laboratory for help before a working clinical impression has been reached; and failure to stick to the working diagnosis throughout the course of the illness.

2. Categorizing the jaundice as to type whether pre-hepatic, hepatic, or post-hepatic is essential, and is the basis for etiological diagnosis, and the background for therapy and handling the case.

3. Considerable overlapping of the results of laboratory tests occur between cases of medical and surgical jaundice, causing much confusion. This is usually the result of intrahepatic obstruction in parenchymal disease, and secondary biliary hepatitis in cases of prolonged obstruction.

4. On the basis of a careful interpretation of the history and physical findings, an accurate working diagnosis can be achieved in 75% of cases seen.

5. Laboratory tests which are dependable in adding to the differentiation between the groups of jaundice are bile pigment studies particularly in the urine early in the course of the disease, the flocculation tests, alkaline phosphatase determination, and the prothrombin response to vitamin K administration.

6. Liver biopsy is the most effective means available in differential diagnosis and in the determination of etiology in cases of jaundice, and should be employed in instances of any question.

7. Using all technics, an accurate diagnosis should be possible in 90 to 95% of all cases of jaundice.

Some Problems of Biliary Tract Surgery

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Our present standards of treatment of biliary disease are the product of development through three periods of medical history[1]. The first covers the centuries from the mid fourteenth to the eighteenth. During this time anatomists and pathologists began to discover a variety of stones in the biliary tract and to correlate their presence with the symptoms of biliary colic and cholecystitis.

The participants of the second period, 50 to 75 years ago, perhaps deserve the greatest merit for courage. Although the removal of ovarian tumors from the lower abdomen had already initiated the development of abdominal surgery, the upper abdomen continued to command more fear and respect. Kocher, Sims and a few others were cautiously draining gall bladders in the late 1860's. In Louisville, we are geographically between two important points in medical history. We all well know the remarkable story of the first ovariotomy by Dr. McDowell in Danville in 1809. Perhaps less well known to you is the fact that the first cholecystostomy in this country was performed in Indianapolis in 1867 by Dr. John S. Bobb.

During the past decade, emphasis has shifted from technique to the study of the physiology of the liver and the biliary system and in particular, the relationship of biliary disease and biliary surgery to hepatocellular damage and repair. The preparation of the patient so as to offer the greatest resistance to liver damage during surgery, as well as the recognition and avoidance of many modes of producing periods of hepatic anoxia and the avoidance of hepato-toxic agents have shown their indisputable value in improved morbidity and mortality statistics.

Despite these major contributions of the past, problems persist in many aspects of diagnosis and management of biliary disease. We would like to enumerate several of the more interesting of these and to comment briefly on some available methods of dealing with these problems. None of these methods are new or original, but the fact that their use is not yet

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widespread would seem to justify their discussion.

Operative Cholangiography

By this is meant, of course, X-ray examination of the biliary tract in the operating room during surgery. Every time a cholecystectomy is performed, a decision must be reached whether or not to explore the common duct. In practice, many patients will have definite indications for choledochostomy. A considerable number, however, will have equivocal indications. Lacking facilities for immediate cholangiography, the surgeon usually feels it wisest to proceed with a common duct exploration in these cases. Operating on this basis, approximately 50% of these procedures prove unnecessary[2]. In patients in whom no indication for choledochostomy is present, a significant number will nonetheless have one or more calculi present in the common duct or the hepatic radicals. In the former group, operative cholangiograms may prevent needless common duct surgery; in the latter, its routine use will decrease the incidence of overlooked common duct stones. Also, a common duct exploration unfortunately, does not assure removal of all stones. Despite meticulous care and the employment of the usual devices and maneuvers, most surgeons share the experience of occasionally finding, in the postoperative cholangiogram, made 8 to 10 days following surgery, a shadow indicating a residual stone in the common duct. Under these circumstances, a trial period of ether-oil irrigation by the method of Pribram is justified, but success with this method has been limited to a few patients with the soft, crumbly variety of stone. In most instances, a second operation is necessary.

Equally satisfactory X-ray examination of the biliary tract following common duct exploration may be obtained immediately at the operating table. If a residual stone is found, re-exploration may be performed at once, sparing the patient a later procedure.

The following illustrations are of cases in which operative cholangiography has seemed useful.*

Fig. 1 shows a normal operative cholangiogram made through a T-tube to exclude residual stone following common duct exploration: The left half of the figure is the actual X-ray; the right half is a tracing. You see a T-tube in the common duct, the common duct emptying into the duodenum, and in this case, reflux into the pancreatic duct. No residual stones are present.

Fig. 2 is also a negative cholangiogram with unusual demonstration of the duodenal cap as well as the biliary tree. We have to date not discovered, with this technique, any residual stones following choledochostomy. However, in 146 cases using cholangiography after common duct exploration, Mixter found 19 cases, or 13% with residual stones which would probably have required later operation.

Fig. 3 is a diagrammatic presentation of the technique we are now using as routine in nearly all cholecystectomies. We have hesitated to inject dye into the gall bladder for fear of washing stones into the common duct, and we prefer to first ligate the cystic duct, then inject the duct proximally through a small ureteral catheter. This is done to avoid overlooking stones in common ducts which, according to the usually accepted criteria, would not be explored.

The following case, shown in Fig. 4, illustrates the value of this type of study. In this case there was no history of jaundice, chills or fever. The common duct did not appear grossly abnormal and no



Figure 1



Figure 2

*(X-rays were made by Dr. H. L. Townsend. We are indebted to him and his department for their assistance).

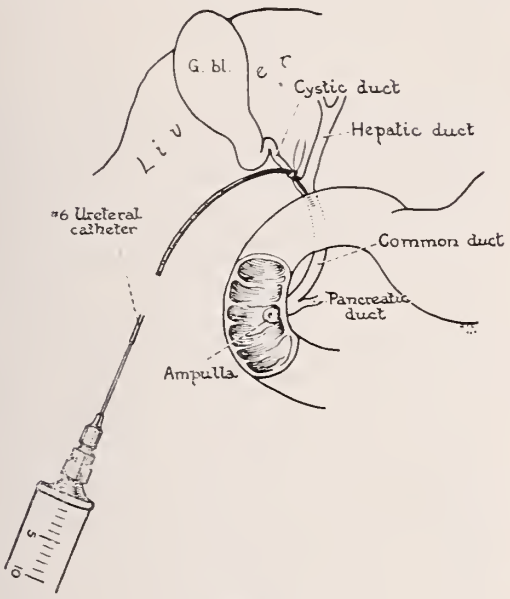


Figure 3

stone was felt in the duct. This common duct without operative cholangiography would not have been explored. By X-ray visualization, however, a stone is clearly seen, which was removed.

The postoperative film (Fig. 5) shows no further calculi present.

Fig. 6 shows a case of acute cholecystitis: A stone impacted in the cystic duct and several others were removed. The films were made at operation, injecting the contrast media through a cholecystostomy tube. The patency of the cystic duct is confirmed, and no stones are seen in the common duct. Emptying into the duodenum is normal.

In performing palliative cholecystenterostomy for obstructing neoplasm in the pancreas where the patency of the cystic duct is so essential to the efficacy of the procedure, this means of visualizing the cystic duct may also be of value.

Occasionally, in spite of a careful history and physical examination, and confirming laboratory or X-ray data, a patient thought to have stones will be found, at operation, to have a thin, blue-walled gall bladder without palpable stones. Fig. 7 was such a case. A cholecyst-cholangiogram confirmed the absence of stones or other abnormality. To remove such an organ, not only does not help the patient, but the symptoms are often aggravated. By exploration and further study, other sources of the complaint should be sought. It is rarely justified to remove a non-calculus gall bladder. The incidence of calculi present in gall bladders removed by the authors during the past ten years was 98%. The surgical mortality for this group was 0.4%.

Operative cholangiography, which only in the past several years has been gaining popular application, is far from being a new idea. The idea was suggested by Cotte in 1929[3], but the Argentine surgeon, Mirizzi[4] first applied and reported the method in 1932. The procedure has been widely accepted in Sweden and favorable results were reported recently by Swedberg from the University of Lund[5]. He found, prior to the use of operative cholangiography, common duct calculi were found in 8.5% of 786 patients. With the routine use of operative cholangiography, in 700 patients common duct stones were found in 16.1%; a statistically significant



Figure 4



Figure 5



Figure 6



Figure 7



Figure 8

increase of 7%. In this country, Hicken[6], at the University of Utah, and Mixter and Hermanson[7] at the Harvard Medical School have reported the largest series and advocated its use. The senior author and H. L. Townsend[8] reported preliminary experience with the method in 1947 and advocated its wider application. In the past several years, an increasing number of favorable reports have appeared, including this year a report by Pirkey[9] and associates on the method as used at the University of Louisville School of Medicine. The technique has been well described previously and will not be repeated here.

Fig. 8 shows a patient in whom a calculus gall bladder was removed six weeks following an attack of acute pancreatitis. Operative cholangiography in this instance confirms the patency of the papilla of Vater and adequate emptying into the duodenum. If the sphincter is to be dilated at all, in such a case the use of small French woven catheters is to be preferred rather than metallic dilators. If there is any question about the patency of the sphincter, it is preferable to open the duodenum and inspect the papilla directly.

Transduodenal Approach to the Common Duct

As mentioned by Hardy[10], "There is still widely prevalent an exaggerated reluctance to open the duodenum even when this maneuver is indicated as a part of the adequate exploration of the common duct." This reluctance stems largely, no doubt, from fear of duodenal fistula or fear of infection from the open bowel. It has been our impression, and that of many others, that properly performed open procedures on the intestinal tract, particularly on the upper portion of it, carry no increased morbidity or mortality. The incidence of duodenal fistula following elective duodenotomy with adequate mobilization of the duodenum and a longitudinal incision carefully closed transversely will be extremely low. Properly cared for, should this complication occur, the outlook is good for healing of the fistula and recovery.

What are the advantages of opening the duodenum? Most important is the direct visualization of the papilla of Vater. A stone impacted in the ampulla may be located, the sphincter incised and the stone removed under direct vision.

Stenosis, or if it seems indicated, spasm of the sphincter may be treated by direct sphincterotomy. Benign polyps and malignant neoplasms of the ampulla may be recognized, biopsied and appropriately treated. And finally, probes, catheters or long T-tubes may be guided through the pancreatic and duodenal portion of the common duct with less hazard or false passage. Also it is possible, when feeling through the unopened duodenal wall, to obtain a false impression that a dilator has passed the sphincter into the duodenum, when actually, this may not be the case. This is avoided under direct vision. With increased use of duodenotomy, stenosis of the sphincter of Oddi will probably be more frequently encountered than anticipated.

The transduodenal approach also is not a new idea. McBurney, whose name is linked with appendiceal incisions, advocated its more frequent use as early as 1898[11]. Cattell[12], Allen[13], Mahorner[14] and others have reported series in which the advantages were stressed and the complications reported were few.

Cholelithophone

Before leaving the problems of common duct surgery, we wish to mention one other addition to the biliary surgeons' armamentarium. This instrument, simple in principle, carries the imposing title of the Kirby-Thurston Cholelithophone. It consists of Bakes type dilators attached to a crystal and an amplifying system. The effect is to magnify and transmit into the operating room the sound caused by contact of the dilator with any hard object. When passing into the common duct, contact with a hard stone will produce an easily audible and recognizable sound.

This instrument has its advantages and its limitations. Soft stones may fail to produce the characteristic click, or stones recessed in diverticuli, or high in the hepatic radicals may avoid contact. As an adjunct to operative cholangiography, and particularly where operating room X-ray facilities are lacking, the instrument is helpful in identifying calculi in the hepatic ducts and lower portions of the common duct and ampulla.

Duodenal Drainage

The problems of diagnosis and management of stones in the gall bladder are considerably less than in the case of the common duct. We would like to discuss briefly one type of patient with cholecystic disease who does present a diagnostic problem. This is the patient with typical symptoms of calculus cholecystitis, perhaps associated with transient evidence of a right upper quadrant inflammatory process, but in whom repeated satisfactory cholecystograms fail to show stones. It is well known that small stones may fail to be visualized on X-ray examination, and yet cause biliary colic or cystic duct obstruction and acute cholecystitis. In this type of patient, diagnostic use of duodenal drainage may prove of considerable value. This is not a routine laboratory procedure. It requires several hours work by an experienced person to pass a tube into the duodenum near the papilla of Vater under fluoroscopic control, to collect specimens of hepatic and gall bladder bile, and then to examine accurately, microscopically, the sediment of a well centrifuged portion. So performed, however, the finding of bilirubinate or cholesterol crystals is the best laboratory evidence of the presence of calculi and is sufficient to warrant cholecystectomy.

Nutritional Preparation of Patient for Biliary Surgery

In recent years, as a result of the work of Ravdin[15] and others, emphasis has been turned toward physiological protection of the liver during biliary disease and surgery, particularly in the jaundiced patient. Jaundice is seldom a surgical emergency. In few other conditions is the preoperative study and coincident preparation so important. The decrease in morbidity and mortality of surgical lesions of the biliary tract in recent years is in large part due to the results of animal experimentation to determine factors in preventing liver injury and aiding repair. No other organ has as great an ability to regenerate itself as the liver. Conversely, few organs are as susceptible to such a wide variety of toxic agents. Glycogen, per se, does not protect the liver. The susceptibility of the liver to damage is in proportion to the concentration of hepatic lipid. A high protein, high carbohydrate diet with sufficient fat to insure an adequate caloric intake seems to afford the greatest protection.

Anoxia in some form is probably the most frequently encountered condition affecting the liver adversely. This may be produced in many ways. Poorly controlled anesthesia, respiratory depression, hypotension or impaired circulation due to gastric dilatation all have similar effect. In addition, certain anesthetic agents and by-products of infection have a direct hepato-toxic effect. The more protein depleted the patient prior to exposure, the greater will be the degree of injury. Conversely, the better the diet, the more rapid will be the repair.

Granting the importance of the high protein, high caloric intake, one is often faced with the problem of the anorexic patient who will not eat adequate amounts. If tolerated, the oral route of administration of protein is, by far, more effective than the intravenous. Tube feedings often solve this problem. A very small polyethylene tube passed through the nostril into the stomach is well tolerated by most patients and can remain indwelling for several days at a time. The patient continues to eat and drink around this tube while receiving, in addition, two to three hundred grams of protein and up to four or five thousand calories a day as supplemental feeding through the tube. During this period of nutritional arma-

ment, restoration of blood volume if necessary, achievement of a normal prothrombin value, vitamin supplementation including choline and methionine, and psychological preparation of the patient may materially increase his tolerance of the necessary surgery.

Summary

In coping with several problems of biliary tract surgery, the following procedures have been found of value.

1. Operative cholangiography may reduce the number of unnecessary common duct operations, may avoid overlooking common duct stones during routine cholecystectomy, or residual stones following choledochostomy, and may aid recognition of congenital anomalies, neoplasms or inflammatory changes at the sphincter of Oddi.
2. The transduodenal approach allowing direct visualization of the papilla of Vater is indicated whenever there is reason to suspect the presence of a stone impacted in the ampulla, benign or malignant neoplasm of the papilla or obstructing inflammatory changes in the region of the papilla of Vater.
3. The cholelithophone is an additional useful instrument in the biliary surgeons' armamentarium.
4. Diagnostic duodenal drainage is particularly helpful in the patient suspected of having cholecystic disease, in whom the cholangiogram is reported normal.
5. The nutritional preparation of the patient for biliary surgery by protecting the liver from damage and aiding its repair is of greatest importance. Appreciation of the physiology of the liver and the biliary system has probably done more to lessen the morbidity and mortality of biliary tract surgery than have refinements of operative technique.

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Anesthesia for the Patient in Shock

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With the increasing accident rate and the ever present possibility of catastrophe, the importance of the care of the patient in shock is evident. In 1941 Harkins compiled a list of twenty-five different definitions of shock from medical literature dating back to 1826. Davis[1] after reviewing these and other references defined shock as "a state involving the entire organism characterized by a general impairment of the circulation, and caused by any form of stress or injury which reduces the output of blood from the left ventricle of the heart to a level below that needed for normal cellular function and metabolism." To paraphrase this, one might say that either the pot is too big or the soup is too scant.

Classification

In order that uniformity exist in discussion of shock like states, some classification must be made. The one proposed by Davis seems logical and simple.

a. Traumatic shock
b. Hemorrhagic shock
c. Burn shock
d. Obstetric shock
e. Medical shock
f. Operative shock
g. Anesthetic shock

Even more simply the classification might be stated as hemorrhagic shock and non hemorrhagic shock. I propose to confine my discussion primarily to traumatic and hemorrhagic shock which nearly always accompany each other, and result from reduction in circulating blood volume.

Evaluation

The information concerning shock accumulated by the committee on Traumatic Shock and Blood Transfusion of the British Medical Research Council[2] covered a vast amount of material. The emphasis placed on reduced blood volume seems particularly pertinent and their correlation of clinical condition and blood volume is shown in Table 1. Two important signs are not shown, the quality of the pulse, and the capillary refill time.

If the blood volume is reduced by no more than 1000 c.c., compensatory vasoconstriction can keep the blood pressure near normal levels. When reduced beyond this amount cardiac output falls, tissue circulation is impaired and anoxic damage to brain and kidneys[3] may occur. It is generally accepted that restoration of blood volume prevents further deterioration, and should precede operative measures, except where the nature of the injury makes restoration impossible without surgery. Once the symptoms of shock are relieved, every effort should be made to prevent further blood loss as a very delicate balance exists. An unusual form of circulatory collapse observed 6-72 hours after severe injury involving the extremities is the result of fat embolism[4]. It does not respond to blood transfusion and if the patient survives, there is improvement from the fourth day onward. The renal syndrome following severe crushing injuries must also be handled with special care.

Management

The severely injured person brought to the hospital deserves the best in cooperative care by resident, surgical and anesthesiological personnel if his life is to be saved. A well organized plan of action should be followed immediately on admission to the hospital.

HISTORY: The nature and elapsed time since the accident, and the amount of blood lost, as well as any previous illnesses such as diabetes, kidney disease or cardiac difficulty should be obtained. Any medication administered prior to admission should be noted.

PHYSICAL EXAMINATION: Starting with the head, all important signs should be observed as well as the nature and extent of wounds. Particular attention should be paid to the patency of the airway, good exchange should be established and oxygen started if indicated. While examining the extremities blood pressure should be taken, the quality and rate of the pulse noted and capillary filling time observed. Blood should be drawn for typing and cross matching, and an intravenous infusion of glucose, saline or plasma volume expander (Dextran) started with a large

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TABLE 1

	Clinical Condition	Pulse Rate	Systolic B.P.	Blood Volume
Group I	good	90-110	95mm. & up	75% normal
Group II	serious	120-140	70-90mm.	65-75% normal
Group III	moribund	120-160	0-60mm.	50-65% normal

gauge needle. Blood should be started as soon as it is available, and in severe emergencies Type O blood should be used without cross-matching.

X-RAY EXAMINATION: In the more severely injured person, any unnecessary movement should be avoided. If compound fractures exist, it may be advisable to defer X-ray examination until the patient has reached the operating room and surgical treatment started. This may save the patient one painful episode and lessen the accompanying shock.

TREATMENT: It is my opinion that the patient who is severely injured should be taken directly from the emergency room to the operating room. An unnecessary trip to the ward with further movement in undressing and examining a patient only increases the degree of shock. In a well organized operating room better team work can be obtained in removing clothing, evaluating injuries and treating airway difficulties caused by blood or vomitus. Blood transfusion equipment and necessary drugs are at hand. Here in well lighted and equipped surroundings judgments are more considered and usually better carried out.

1. Restoration of Blood Volume: The restoration of blood volume which should have started in the emergency room by the use of Dextran[5] and followed by whole blood as soon as available is of utmost importance. Aggressive treatment in this direction is life-saving. 500 c.c. of blood is scarcely ever enough to replace the loss in severely injured people. The risk of over transfusion with amounts of 1500 to 2000



Figure 2.—Intravenous transfusion utilizing the "Baxter" plastic hand pump which is placed between blood bottle and drip filter.



Figure 1.—Arterial transfusion utilizing blood pressure bulb manometer.



Figure 3.—Intra-arterial transfusion utilizing the two syringe method. One syringe should be kept clean while the other is in use.

c.c. is negligible. If no response is shown to the venous transfusion of 1000 c.c. of blood, intra-arterial transfusion is indicated, or if a severe degree of collapse is present it should be the first choice of routes for transfusion. The rate of administration of blood transfusion into the venous circulation may safely be 100 c.c. per minute up to a quantity necessary to restore normal volume. Large gauge needles or cannulas inserted into veins by cut-down technique, and the use of pressure systems seem to produce the best results.

2. Maintenance of Airway and Oxygenation: The insertion of an endotracheal tube into an unconscious or severely shocked patient is frequently indicated. During this procedure the upper airway is visualized for the presence of foreign bodies, blood and vomitus: also tracheal aspiration should be carried out. If the larynx and vocal cords are sprayed with a topical anesthetic agent a conscious patient will tolerate an endotracheal tube with little discomfort. After aspiration of blood and vomitus, oxygen should be given by catheter or gas machine. Closed systems are far more efficient than open techniques.

3. Other Measures: Trendelenberg position, maintenance of body warmth, relief of pain by small intravenous doses of opiate should be carried out as indicated. All fractures should be immobilized as soon as noted. Any movement of the patient should be as gentle as possible.

Choice of Anesthesia

After the above regime has been instituted and the surgeon has decided upon his course of action for further treatment, the choice of anesthesia can be made. There is no magic choice of agent for the patient in shock, and all anesthetic agents have relative contraindications. Some of the objections are mentioned below.

A. Chloroform has toxic action upon the myocardium and liver especially when anoxemia exists.

B. Ether produces vasodilatation and further reduces blood pressure in addition to its explosive and irritating qualities.

C. Nitrous Oxide increases anoxic tendencies with resulting depression of respiratory and circulatory centers.

D. Cyclopropane is accompanied by post anesthetic blood pressure fall in addition to explosive and cardiac depressant factors.

E. "Pentothal" depresses respirations and causes hypoxia in addition to impotency and prolonged recovery time.

F. Spinal anesthesia depresses blood pressure and may be difficult to induce in an injured patient who is uncooperative.

G. Regional Anesthesia such as brachial or sciatic block causes vasodilatation of the area, and often proves ineffective and unsatisfactory to the uncooperative patient.

H. Local infiltration of large areas may produce toxic effect from absorption of the agent with further depression.

If there is any definite indication for choice of anesthetic, it should be in favor of the one producing the least physiological disturbance in the patient. The type of anesthetic with which the administra-



Figure 4.—Davis-Patient Roller - Position No. 1.



Figure 5.—Position No. 2—The Davis Patient Roller in use enables limited personnel to move patient gently regardless of size.

tor is most adept and controls with the most care should be used if it does not compromise the patient's safety. The use of endotracheal technique when blood or vomitus presents a problem insures safety of administration. All agents should be employed in the lowest effective concentration possible.

The majority of shock patients under our care receive "Pentothal" — nitrous oxide anesthesia. A relaxant, usually succinyl-choline chloride by drip technique, or ether is added as indicated. There is evidence that barbiturates do not significantly affect the outcome of experimental animals which have been thrown into hemorrhagic shock[6]. Likewise, the analgesic effect of nitrous oxide can be obtained with concentrations which do not deprive the patient of oxygen. A rapidly hydrolyzed relaxant such as succinylcholine chloride aids in placing an endotracheal tube in position, as well as obtaining the relation of muscles as indicated by the surgery. The vasodilatation produced by light ether anesthesia is not considered detrimental to a patient in shock, and might well be of some advantage in shock therapy.

Recent investigations[7] of irreversible shock in dogs indicate that the survival rate is markedly increased if sufficient dibenamine is given to prevent peripheral vasoconstriction. The introduction of easily controllable ganglionic block agents such as "Arfonad" may be of value in the treatment of shock, but only after full attention has been given to restoration of blood volume.

Summary

The problem of shock therapy has been briefly discussed in relation to the choice of anesthesia for patients in shock. Emphasis has been placed on the vital importance of restoring the blood volume as rapidly as possible. Physiological basis for choosing and maintaining anesthesia has been stressed. A new approach to shock therapy in relation to peripheral vaso-constriction has been mentioned. In conclusion it might be stated that anesthetic management of patients in shock is primarily one of treating shock.

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Peptic Pathology, The Practitioner's Problem

COLEMAN C. JOHNSTON, M.D. F.A.C.S.

Lexington

To those of us interested in gastric surgery it is quite evident that the problem of peptic pathology is one of paramount importance. The types of gastric, duodenal and gastroesophageal pathology are so numerous that time will permit of only a sketchy review.

Ten per cent of all adult males and about four per cent of all women under-go treatment for duodenal ulcer. Gastric ulcer is found one-fourth as often. 40,000 patients die in the United States each year from gastric cancer. The life expectancy of untreated gastric cancer is three years. This means at one time 120,000 people are living with cancer of the stomach. In short, these groups in addition to other less common pathological alterations comprise a sizeable number of our population.

Yearly millions are spent by the dyspeptic for useless drugs and if we, as physicians, could channel this wastage into avenues of diagnostic and therapeutic value, we would contribute much to our people.

With a careful history, thorough physical, and the use and re-use of a competent roentgenologist and gastroscopist, many lesions now over-looked should be discovered. Recently cell studies from gastric washings obtained by the abrasive Cooper balloon have helped to uncover more early gastric malignancies.

Based on the surgical management of 81 patients suffering from upper gastrointestinal disease and the gastroscopic examination of 259 patients, it was felt that a few comments might help to refresh our thinking and renew our interest in the diagnosis and treatment of upper gastrointestinal disease.

Less Common Conditions

Foreign bodies are rare except in children and the insane. Congenital hypertrophic pyloric stenosis is seen in about five boys and one girl per thousand. The clinical picture is characterized by projectile vomiting, bile free vomitus, visible peristalsis and often a palpable tumor. The X-ray picture is one of complete obstruction, or a trickle of barium flowing through the fine pyloric lumen. The Ramstedt operation of dividing the cartilaginous fibers down to the mucosa is the one procedure in gastric surgery that is universally accepted.

Pyloric hypertrophy is occasionally seen in the adult. The cause is unknown. Treatment is the same as above, or a conservative resection may be used.

Prolapse of the gastric mucosa with the characteristic mushroom-like deformity as seen on X-ray is said to be more common than gastric ulcer. Symptoms may range from mild indigestion to episodes of excruciating epigastric pain with back radiation, nausea, vomiting and at times severe hematemesis. Surgical excision of the redundant mucosa and pyloroplasty or minimal resection may be necessary.

Peptic Ulcer

Although the term peptic ulcer includes gastric, duodenal and postoperative marginal ulcer, each lesion is a definite and distinct entity with specific characteristics which not only alter the course and prognosis of the disease, but requires for these different characteristics specific forms of management.

All three have in common those complications which are considered indications for surgical intervention, namely, obstruction, perforation, intractability and bleeding. The gastric ulcer may occur in the presence of a low acid in the phlegmatic individual by contrast to the high acidity of the driving patient with duodenal ulcer. A malignant lesion, almost never seen in the duodenum, is a constant threat in lesions of the gastric mucosa.

Time does not permit a discussion of the cancer-ulcer relationship, but suffice it to say that medical management, safe in the duodenal or marginal ulcer, is generally agreed to be dangerous in the gastric ulcer.

Most surgeons feel that all gastric ulcers should be resected. The internists are less radical. The roentgenologist cannot distinguish between ulcer and early malignancy and besides, both symptoms and X-ray findings in early malignancy may disappear with medical management. Unless a gastric ulcer is observed to heal by repeated gastroscopic examinations at

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about ten day intervals, it should be explored, biopsied and resected.

At gastroscopic examination we observed an inoperable cancer in a 64 year old woman treated for one year following X-ray diagnosis of a benign ulcer. Again, a 27 year old white man, diagnosed benign ulcer by X-ray required a total gastric resection for removal of his malignancy after six months of medical management. He died of recurrence eight months after operation.

The posterior wall ulcer is often a difficult lesion to discover on X-ray examination.

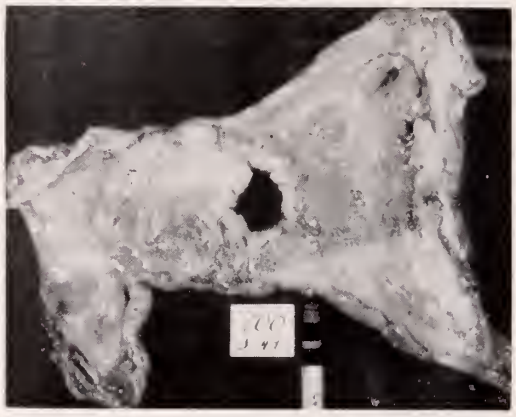


Figure 1

This lesion was reported as a malignancy, but at operation proved to be benign, penetrating into the body of the pancreas. Two similar lesions found at operation after repeated negative X-ray studies, in addition to other diagnostic difficulties compelled us to determine the value of gastroscopy. Dr. Schindler, the inventor of the flexible gastroscope, was contacted and a month was spent with him in Los Angeles studying gastroscopy. Since that time we have taken up gastroscopy in Lexington and have gained much valuable information by its use.

Gastric ulcer, in contrast to duodenal ulcer, responds quite satisfactorily to the more conservative resection, with far fewer postoperative complications, a negligible incidence of recurrence and a lower operative mortality. Occasionally two or more ulcers are found.

Recently a specimen, resected from a white man of 71, admitted for upper gastrointestinal bleeding, showed two distinct craters in the gastric mucosa, one at the pylorus and a larger one proximal thereto. The convalescence was uneventful. Petz sewing clamp, which is an excellent and time saving instrument. The convalescence was uneventful.

A partial gastrectomy is generally conceded to be the operation of choice. However, local excision in the elderly may be justified as in a 70 year old white woman, with X-ray findings suggesting malignancy. At gastroscopic examination she presented the picture of a benign ulcer high on the lesser curvature, justifying local excision. She did well until three and one-half years later, when symptoms recurred with hematemesis. X-ray studies revealed a second ulcer in a large hiatus hernia. She was relieved of her symptoms by division of the phrenic nerve and the ulcer was reported healed on X-ray examination four weeks later. Gastroscopy is contra-indicated in hiatus hernia.

Choice of Operation

The type of surgical operation for duodenal ulcer is not as yet entirely settled but more and more it is felt that a resection of about three-fourths of the stomach is the procedure of choice. A hemigastric resection with vagotomy may prove worthwhile. The Polya or Hofmeister are the procedures most commonly used, and recenty Dailey has suggested a modification to minimize the incidence of the dumping syndrome. This disturbing postprandial weakness with syncope and at times cramping abdominal pain, occurs following from 3 to 5 per cent of partial gastric resections. It is more common

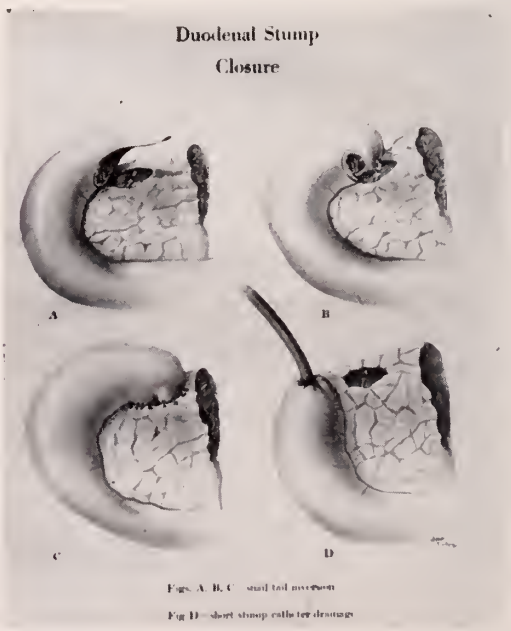


Figure 2

after total gastrectomy. We find it responds best to dry diet with minimal liquids and reclining after meals.

The incidence of postoperative complications, following resection for duodenal ulcer, considerably higher than for gastric ulcer, is dependent to a great extent upon difficulty in closing the duodenal stump.

Figure 2 represents the Snail Tail closure and the catheter drainage of the duodenal stump.

At times with a posterior wall ulcer the Snail Tail inversion is a handy procedure. As seen in the right lower illustration D. of Figure 2, the catheter stump drainage is best used when the duodenal remnant is too short for secure closure.

Complications of Peptic Ulcer

In discussing complications of peptic ulcer which are regarded as indications for surgical intervention, first let us consider obstruction: Pyloric obstruction may also result from benign or malignant tumors, but the acute or chronic inflammatory changes resulting from gastric or duodenal ulcer account for by far the greatest majority of pyloric obstruction seen in the adult. Not infrequently these gastric cripples are found to have a tremendously dilated stomach following prolonged obstruction. Partial resection is the operation of choice. The elderly, depleted patient with a low acidity is the only remaining indication for the once popular gastroenterostomy.

In the treatment of perforated peptic ulcer a new departure from simple closure has been presented in the literature. It is important to know that reliable surgeons have tried the conservative, non-operative treatment of perforated ulcer, using continuous gastric syphonage, sedation, antibiotics and intravenous fluids. The mortality has been considerably lower than one would expect. One should be aware of this mode of treatment for two reasons. First, because it is well to know what not to do, and second because in some remote area where surgery is not available this treatment might well prove life saving.

In the last decade a good deal has been written about resecting a selected group of patients admitted in good condition shortly after the perforation of an ulcer. The reason for this development is that following perforation, the incidence of recurrent ulcer, recurrent perforation, subsequent obstruction, or other difficulties requiring further surgery, ranges somewhere between 30 to 40 per cent. For example, a 52 year old patient perforated 2 years ago and at resection because of intractable pain, he was found to have two distinct ulcer craters in the duodenum. In retrospect we feel that a number of our patients might well have been resected at the original operation.

The resistant ulcer which fails to respond to medical management, or the ulcer in the individual who cannot or will not follow proper medical management is considered intractable. Operation is the only alternative.

Upper gastrointestinal bleeding may be acute, severe and profuse, or it may be a slow, chronic, weeping blood loss. It may pump vigorously from an eroded gastric or duodenal artery, or drip steadily from an ulcerated tumor either benign or malignant. It may follow trauma. In the ulcer patient who sustains a severe injury or is subjected to operation for some other cause, sudden massive hemorrhage may occur.

Following upper respiratory infections, bleeding in the ulcer patient is not uncommon. The use of Cortisone or ACTH has been recorded as precipitating ulcer hemorrhage. In this day of "Dicumarol" therapy in coronary disease, the ulcer patient may bleed profusely. One of our patients, a 45 year old salesman, having had two episodes of coronary occlusion had been on "Dicumarol" for four months. He was known to have had a duodenal ulcer for four years. After a period of indulgence, he had a severe hemorrhage. "Dicumarol" was withdrawn, he was given Vitamin K, adequate blood replacement and resected within 24 hours. He had an uneventful course and anti-coagulant therapy was instituted on the second postoperative day.

Vomiting with severe retching may initiate profuse bleeding. Two cases have been observed, one a boy of 14, who became ill after rapidly consuming a large bag of popcorn. He vomited, retching vigorously, then vomited a large quantity of fresh blood. Thereafter he had no further difficulty.

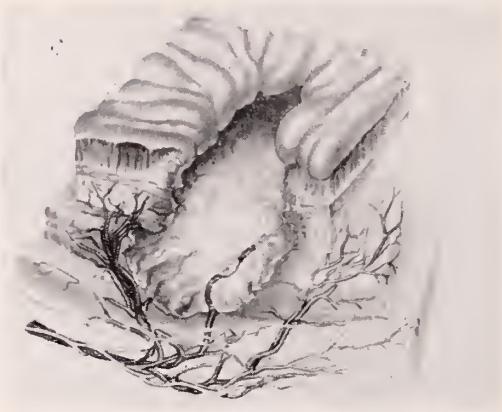


Figure 3

The illustration in Figure 3 is a diagramatic composite of this and five similar autopsy specimens viewed since that time, none of which have been my own. Note the penetration of the ulcer down to the vessel, with erosion through the arterial wall. In those over 45, with aging arteries rigidly fixed in the dense fibrous scar tissue of a chronic ulcer bed, there is a complete absence of all elasticity with fixation and rigidity which mitigates against the arrest of bleeding. It is in this type of gastric and duodenal ulcer hemorrhage that the ultimate outcome of medical management is invariably fatal. The location, cause of bleeding and quantity of blood lost, are those features which we are interested in determining as quickly as possible in the acute, severe bleeding. In the chronic, or slow persistent blood loss, haste is unnecessary. Between seven and ten per cent of these severe hemorrhages will prove fatal in spite of every therapeutic measure available, short of a direct surgical attack. Therefore it is essential to establish a diagnosis and then if operation is indicated, it should be carried out as soon as the patient's condition will warrant exploration.

Fifty per cent of all gastric and duodenal ulcers bleed and 35 per cent of marginal ulcers bleed. Gastric and duodenal ulcer cause 75 per cent of upper gastrointestinal hemorrhage. Esophageal varices and diffuse gastritis comprise 15 per cent. The remaining 10 per cent are attributed to benign or malignant tumors, polyps, prolapsing pre-pyloric mucosa, duodenal diverticula, or the other less common pathological alteration, including systemic disease such as sepsis or one of the blood dyscrasias. The sex ratio is 9.5 to 1, male predominating. Although severe bleeding is four times more likely to occur from duodenal ulcer, the death rate from ulcer hemorrhage of the stomach is about eight times the mortality of duodenal ulcer bleeding. Having once bled, 60 to 70 per cent of these patients will have recurrent hemorrhage. Conservative treatment should be tried, remembering that there is a 7 to 10 per cent mortality. In those over 50 the death rate is four to six times that in the younger group.

In May 1939, the late Dr. Robert Downing had the courage to examine for me, by means of the then unheard of Hampton X-ray technique, a 47 year old white male in the process of bleeding from 3.5 million down to 880,000 RBC in the course of eight hours. Immediately X-ray revealed evidence of duodenal pathology, the patient was removed to surgery. Large quantities of blood were administered. Exploration proved that a chronic penetrating posterior wall duodenal ulcer had eroded into the pancreaticoduodenal artery. A gastric resection was done, bleeding controlled and the patient recovered.

We have done partial gastric resections for severe ulcer hemorrhage on 18 patients. There were two deaths, one a 300 pound diabetic who died of pulmonary complications on the third postoperative day. The second succumbed to an unrecognized proximal loop obstruction. The former would not have survived medical management because of the deep destructive erosion into the head of the pancreas. The latter might have survived without emergency operation.

Management of Hemorrhage

The following routine has been established for the management of upper gastrointestinal hemorrhage: 1. Sedation, with barbiturates preferably. 2. Hospitalization. 3. Immediate blood studies to rule out blood dyscrasia. 4. Blood replacement. 5. A thorough history and physical examination. 6. Surgical consultation. 7. Upper gastrointestinal X-ray studies, if the patient is not in shock, using the Hampton Technique. If a gastric or posterior wall duodenal ulcer is found by X-ray, it must have a pretty large crater to be visualized. Because the pancreaticoduodenal artery or branches of the gastric are so easily eroded, we feel that surgery must be delayed only long enough for rehabilitation. If no gastroduodenal pathology is present, esophageal varices must be suspected. This will be discussed subsequently.

Finally if neither ulcer or varices are found, the energetic supportive measures instituted are continued. Pulse and blood pressure are recorded at fifteen minute intervals to help determine the extent and duration of bleeding. 1000 cc of blood is made available. Sedation is maintained, remembering morphine is poorly tolerated in shock. Nasal oxygen is begun. We feel the Levin tube and constant suction will help to empty the stomach of acid secretions and may shed light on the location, extent and duration of bleeding. Rigid adherence to this routine, even in those patients who first appear to be only moderate bleeders, will avoid unnecessary confusion and often dangerous delay. Some time ago a patient hospitalized for three days because of massive upper gastrointestinal hemorrhage died fifteen minutes before we were able to complete the consultation requested by the internist just two hours earlier. The surgeon, therefore, must be called early if the best results are to be obtained.

In one white male of 60, an exsanguinating hemorrhage occurred in a small superficial ulceration of the prepyloric mucosa. The acute ulcer was not palpable and could only be found after opening the stomach. A small artery 2 mm. in diameter was discovered still pumping vigorously after 24 hours. An anterior Polya resection was followed by an uneventful recovery. This patient would have succumbed to conservative management.

A gastrotomy is frequently useful. At times a sterile proctoscope may be necessary to discover the superficial ulceration or diffuse petechial bleeding. It is also helpful in visualizing the small lesion well up in the cardia. At times bleeding from small bowel tumor confuses the picture. Always, at abdominal exploration, if obvious pathology is not evident in the stomach or duodenum, the entire small bowel should be carefully read before opening the stomach, for recently a small bowel tumor was found in a 52 year old colored woman who was studied twice previously for severe upper gastrointestinal bleeding.

If operation is indicated, the direct surgical attack is the procedure of choice. The high gastric ulcer may be excised locally but other gastroduodenal ulcerations should be removed by resection. Vagotomy alone, vagotomy with gastroenterostomy or with pyloroplasty in the face of bleeding from such a lesion would, of course, be ridiculously inadequate.

Eads and Schiff state that the source of between 6 and 26 per cent of upper gastrointestinal bleeding will remain undiscovered. Recurrent bleeding is not uncommon, yet still the source cannot be found after repeated careful studies. Fortunately in these patients bleeding is rarely fatal. Bleeding will often obliterate the crater defect. For this reason one cannot overemphasize the importance of gastroscopic examination immediately after bleeding has ceased. It is unlikely to start further bleeding. Often weeping from a small superficial erosion, never revealed by X-ray examination, can be observed under direct vision. Other forms of bleeding, difficult or impossible to discover by X-ray, may also be found by gastroscopy. Perhaps one may best illustrate the value of gastroscopy in undiagnosed upper gastrointestinal bleeding by presenting the findings in two patients thus studied.

First is that of a 60 year old white female, an obese diabetic with progressive weakness and dyspnea of four weeks duration and tarry stools of one week duration, X-ray was negative. Gastroscopy revealed a small punched-out oval ulcer crater with a brownish mass of clotted blood at one extremity which marked the site of arrested bleeding. Seven weeks after conservative management, gastroscopy showed the ulcer to be completely healed. She has had no recurrence.

The second is that of a 43 year old white female with repeated episodes of tarry stools and occasional hematemesis with 40 transfusions during the past twelve years. X-ray studies and esophagoscopy were negative. Gastroscopy revealed a smooth round tumor four centimeters in diameter in the upper half of the stomach. Blood could be seen to drip slowly from the tumor thought to be a leiomyoma. At operation by the referring surgeon, it proved to be an ulcerating leiomyoma sarcoma.

In other instances, post-bleeding gastroscopy has failed to reveal the source, but when we remember that hematemesis has been known to occur from severe bleeding of a Meckel's diverticulum, one is not surprised. In short, a definite percentage of patients will die from upper gastrointestinal hemorrhage, unless operation is carried out to control this bleeding sometime within a reasonable period of the onset.

Planned Surgery

By contrast to emergency operation we feel that planned deliberate early surgical intervention for massive upper gastrointestinal hemorrhage is indicated under the following circumstances:

1. In initial or recurrent bleeding in known gastric or duodenal ulcer.
2. With X-ray evidence of ulcer crater, either gastric or duodenal.
3. In uncontrolled bleeding after 36 hours.
4. In recurrent bleeding after 36 hours
5. After repeated bleeding of unknown origin studied at previous admissions.
6. In neoplastic or polypoid lesions.
7. In proved cirrhotics uncontrolled after 24 hours.
8. In discovered esophageal varices uncontrolled after 24 hours.
9. In patients on "Dicumarol" with ulcer history, after adequate preparation.

Esophageal Varices

In bleeding esophageal varices liver function tests are done and a needle biopsy of the liver is requested. We have devised a simple test to discover bleeding from esophageal varicosities. It is more readily available than is esophagoscopy. A plastic Levin tube is gently introduced through the anesthesized nasopharynx and throat of the patient, elevated to medium Fowler position. The tube is marked for the cardia at 41 cms and gentle suction with a bulb syringe is applied as the tube is passed down the esophagus. With esophageal bleeding of any degree in progress, blood should be caught up in the opening of the tube, which is withdrawn shortly after reaching the 41 cm mark. The procedure can be carried out in two or three minutes. If available, esophagoscopy will substantiate the diagnosis. The Blakemore balloon tamponade has been used but in our hands has proved ineffectual, as it has in the hands of several of my colleagues. A number of operative procedures have been described but when we realize the extent of the varicosities, as found at autopsy, only direct surgical attack would seem plausible. The varicosities are large, tortuous and very thin walled, arising in two or three parallel cords, extending from 7 to 10 cms above the cardia and increasing in size as they progress upward. The perforation is usually well up from the cardia and there are no valves to control back bleeding. In reviewing the various operative procedures used to control bleeding from esophageal varices, which fail to respond to conservative management, the most logical would seem that described by Dr. Linton of Boston. He opens the esophagus and runs an interlocking atraumatic suture along the varix. In eleven patients he has had one death. It is done to tide them over the acute episode. He feels that subsequently a shunting procedure will be necessary, for three of his patients bled again within two months. We have not utilized this procedure but would support the plausibility of a direct attack. Certainly it is a less threatening procedure than total gastrectomy, excision of the lower third of the esophagus and other radical operations that have been advocated. Using the thoraco-abdominal approach for the esophageal lesion, ligation of the splenic artery can also be done to decrease the portal circulation by about 40 per cent of its blood flow. Other esophageal pathology must be differentiated from gastroduodenal disease and for this reason it would seem well to include some of the more common abnormalities.

Other Abnormalities

Cardiospasm which consists of the intermittent or constant spastic contraction of the cardiac orifice of the stomach without organic pathology, presents the typical picture of epigastric pain, dysphagia and regurgitation of undigested food. X-ray reveals the characteristic finding of the dilated, tortuous esophagus. Dilatation is tried and if it fails, then surgical intervention is indicated. Many plastic procedures have been used, notably the Heineke-Mikulicz operation among others, but the Hellar procedure of dividing the circular fibers of the cardia down to the mucosa is considered the safest and most satisfactory.

Diaphragmatic hernia has received a good deal of attention during the past decade. Because of the diversity, inconsistency and variety of symptoms produced by the hiatus hernia, it has been referred to as the ghost of the upper abdomen. Many a gall bladder and not a few stomachs have been needlessly sacrificed on the altar of mistaken identity with a persistence of symptoms that eventually lead to the surgical repair of the hiatus hernia. It may be repaired through the thoracic or abdominal approach. In the

elderly and depleted patient, phrenic nerve block is simple and easy. If effective, the nerve is divided under local anesthesia. In younger patients repair of the hernia is the procedure of choice.

We observed a 75 year old white woman thought to have been a cardiac, bed-ridden four months, suffering from epigastric pain, nausea, vomiting and weight loss. X-ray revealed a large hiatus hernia. Phrenic nerve block gave this patient dramatic relief and ten days thereafter, the nerve was resected under "Novocaine." This patient has been greatly improved.

Another hiatus hernia was found in a 37 year old colored woman with rapidly progressive symptoms of severe epigastric pain with back radiation, nausea and occasionally vomiting. Immediately the diagnosis was established, by X-ray, she requested operation because of the intensity of her pain. The hernia was repaired through the abdomen and she has been symptom free for the past four and one-half years.

Another patient, a 75 year old white woman, was found to have gall bladder disease and a hiatus hernia. Both were discovered at X-ray examination, requested because of slowly progressive upper gastrointestinal symptoms, characterized by severe epigastric pain with back radiation becoming progressively worse. At operation the hernia was repaired and being in good condition the gall bladder and stones were removed at the same time. The patient is symptom free two years later.

The congenital and traumatic diaphragmatic hernias are less commonly observed, but recently we have seen the X-ray of an 80 year old white female who developed mild indigestion while recovering from a fractured femur. Her entire stomach is above the diaphragm and has been there unnoticed for 80 years.

Malignancy

Cardio-esophageal malignancy causing the slow but steady appearance of obstruction does not usually produce the large dilated esophagus. X-ray reveals a constricting lesion and at esophagoscopy usually a biopsy may be obtained. Through the thoraco-abdominal incision the lesion can be excised and from one-half to three-fourths of the stomach may be brought up into the chest for the re-establishment of continuity. Twice we have used the procedure. Following an uneventful postoperative course, the first patient succumbed to recurrence 7 months later. The second appeared to be doing well when she developed a saddle embolus at the bifurcation of the aorta. This we evacuated, but sclerotic vessels and a generalized weeping from anti-coagulants resulted in a fatality.

Malignant lesions of the stomach comprise the most serious and difficult aspect of our problem of peptic pathology.

Carcinoma and sarcoma, though similar in gross appearance, have notably different characteristics.

Sarcoma of the stomach composes about 2 to 3 per cent of all gastric malignancies. They may be lymphoid tissue tumors or may arise from muscle, nerve or fibrous tissue. Their singular significance of utmost importance is that although they have a far better prognosis than cancer of the stomach and respond, often dramatically, to X-ray treatment, they are frequently mistaken for gastric cancer. The advantage of their virtues is thereby lost in the error. The tumor often grows to an extraordinary size, giving little evidence of systemic depletion. Bleeding or the presence of a mass is frequently the first manifestation of a gastric sarcoma. Infiltration is rare and metastasis late, therefore simple local excision is usually sufficient to effect a cure. If the lesion is not resectable, or should postoperative evidence of recurrence present, X-ray treatment may prove highly effective. For this reason it is mandatory that all gastric tumors be explored and a biopsy taken. For example, a reticulum sarcoma proved by frozen section, was removed from a white woman of 51 by partial gastrectomy 15 months ago. To date she has no evidence of recurrence. The gastroscopic finding revealed infiltration suggesting malignancy but the X-ray diagnosis was benign ulcer.

In figure 4, this lesion is an extensive duodenal reticulum cell sarcoma with local



Figure 4

metastasis in a 62 year old colored man removed by a subtotal resection. Three months later he began to lose weight, developed digestive disturbances and epigastric discomfort. This suggested recurrence. Following X-ray treatment a rapid and dramatic improvement was noted. He is symptom free after fifteen months.

Cancer of the stomach, subtle, insidious and devastating in its progress is not only difficult to discover but requires surgical management of diligence, persistence and patience. "Patamine sky blu" injected into the subserosa of the stomach at the beginning of the operation will soon after reveal adjacent gland patterns and facilitate a wider dissection of lymph gland with the total gastric resection.

In a 72 year old colored man admitted with severe anemia, X-ray studies, at first doubtful, revealed suggestive evidence of a tumor on a second examination. Gastroscopy established the diagnosis of a cancer of the stomach.



Figure 5

Figure 5, presents the specimen removed at total gastrectomy. This patient is living and well after 16 months, able to maintain weight and do odd jobs around the house. He has a large soft stool one-half to one hour after each of five daily meals. The total resection particularly in the elderly requires constant postoperative dietary management.

A total gastric resection was done in a little edentulous mountaineer of 65, discharged from the hospital in good health on the 16th postoperative day. He had no evidence of glandular involvement and therefore a good prognosis. Six weeks later he was found living on crackers and clear soups. It was impossible to educate this patient, without dentures, to his proper dietary requirements and he died three months after operation, actually of starvation.

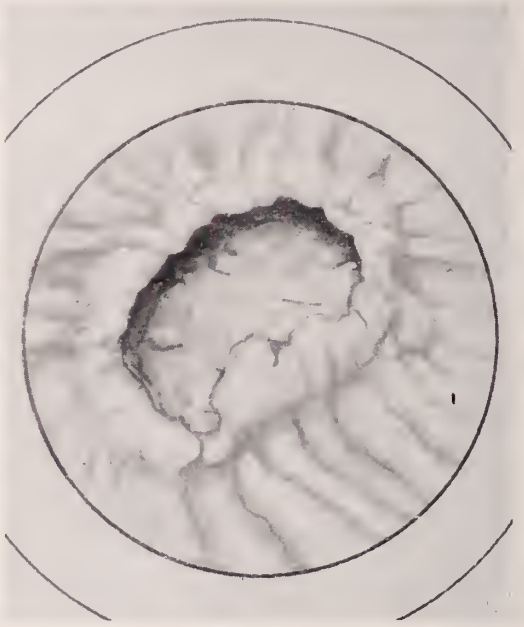


Figure 6

Following a total gastrectomy for a cancer of the stomach in a 42 year old white woman, energetic and anxious to live, the patient gained 26 pounds in about 16 weeks, ate five meals a day without the slightest discomfort except for a severe dumping syndrome only after ice cream or a milk shake.

The previously mentioned 27 year old white man, who was treated six months for a gastric ulcer diagnosed at X-ray, gained 15 pounds in 10 weeks after total resection. Both these latter patients succumbed to metastasis within eight months.

On the other hand after resection by partial gastrectomy of a localized gastric cancer in a man of 68, we have a five year survival without evidence of metastasis.

Gastroscopic examination as illustrated in Figure 6 revealed this large localized cancer on the greater curvature of the body of the stomach, overlooked at two previous X-ray examinations.

Palliative operations other than partial or total resection are of no value. The worth of X-ray treatment is questionable.

Conclusion

In conclusion then, may we emphasize that the passive attitudes of yesteryear, provoked by the surgical inadequacies of

(Continued on page 212)

SPECIAL ARTICLES

THE FIVE GREAT DANGERS TO MEDICINE

Clyde C. Sparks, M.D., Ashland, following his selection as president-elect, directed some remarks to the House of Delegates at the 1953 Annual Meeting of the Kentucky State Medical Association which deserve to be re-emphasized because of their pertinence to the future of medical practice.

"Perhaps the greatest danger," Dr. Sparks said, "is that which comes from within ourselves. It is marked by complacency, lack of willingness to sacrifice, and lack of information."

The key word connected with this danger is "complacency," because the other aspects of the danger within the individual physicians are probably but reflections of it.

Complacency is dangerous for the individual physician for two reasons. First, the face of the medical profession—whether it be in service, or other aspects of medical practice—is frequently but the sum of what all physicians do, say and think.

Secondly, that part of medicine's face which is provided by organized medicine through medical societies—because there are important matters which individual physicians cannot approach as individuals —requires an alert, well-informed constituency if it is to function properly.

In such cases, the wisdom and strength of our profession cannot help but be impaired by complacency on our own parts as individual physicians.

Dr. Sparks reminded the House of Delegates that the danger of "governmental medicine encroaching on our free enterprize system through the increased numbers of people that may be eligible for complete care at public expense through the Veterans' Administration" is a serious one.

The American people have clearly shown that they do not want socialization of medicine when that issue was squarely put before them. They are less alert to the possibilities of its development through the back-door approach. Among the numerous back-doors that are still unlocked is the Veterans' Administration.

If all veterans are to receive government medical care—whether their disability is service connected or not—and if current international conditions continue, it is evident that in a relatively short time more than half of the population will be recipients of a type of socialized medicine. Even discounting the numbers involved, if government medicine is improper for all, it is certainly improper for a few, except where a clearcut obligation exists such as care for veterans with service connected disability.

The third danger cited by Dr. Sparks requires no comment beyond his own words: "The pattern is now being set by the United Mine Workers Welfare and Retirement Fund and the extension of this is seeping into other industries and labor groups. Be not deceived or led into any false security that it cannot happen to you who do not live in mining areas."

One of the most serious matters confronting the medical profession and its future is covered by Dr. Sparks' fourth danger—"the corporate practice of medicine with the possible extension of the idea that hospitals should practice medicine rather than be institutions in which medicine is to be practiced. We should give considerable thought to the intervention of the third party in medical practice."

No physician needs to be reminded of the dangers to the people and the profession's independence which growth of corporate medical practice involves. If others understood the danger as well, its importance would not be great, but what seems to be self-evident to the physician is frequently totally unseen by others. Because of lay ignorance the problem is becoming more acute every day.

Dr. Sparks concluded his enumeration of the five great dangers by reminding the House of Delegates that "still present is the potential danger of a frontal assault by social planners in high government positions."

(Continued on page 203)

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Eleventh District	Hugh Mahaffey, Richmond	1954
Twelfth District	Garnett J. Sweeney, Liberty	1956
Thirteenth District	Charles B. Johnson, Russell	1955
Fourteenth District	John Archer, Prestonsburg	1956
Fifteenth District	Edward Wilson, Pineville	1954

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EDITORIALS

"REAP THE WHIRLWIND"

During the past year, we have witnessed a growing tendency among some members and groups of the medical profession to use national magazines and the daily press as a courtroom in which to try what are essentially internal problems of the profession.

The temptation to take these problems to the people is easy to understand. In one's enthusiasm for what he regards as a problem that must be solved or a new idea which must be sold, any of us may be inclined to overlook the dangers for all which may result from overly pointed criticism of one's colleagues.

Our respect for the press is deep. Its power for good is great. The breadth of its coverage of the reading public is such that it can effectively be used as a club when one has access to it. This is true in medical matters as in others.

The medical profession, composed of thousands of rugged individualists, has always had more than its share of internal controversy. Because controversy makes news, both national journals and the daily press are eager to make their columns available for dissident groups within the profession. Because of the universal concern of the people with matters relating to their health, when such attacks by one segment of the profession are made on another, they are assured of prominent display.

The press, however, does not afford a truly fair hearing. This is not its fault, but it is true. When a jury sits to consider a disagreement, there are safeguards that each side will be equally heard. The jury in a courtroom is compelled to hear all that either side has to present germane to the question. Even then mistakes will be made, but they will be made only on the evidence that is available.

This is not so with the newspaper or magazine. The reader reads only what appeals to him. It is axiomatic that the sensational will draw his attention most readily. It is equally true that he is loath to put forth the effort required in reading long and sometimes involved explanations or answers to charges. Even if everytime a controversial matter were mentioned in the press, both sides were presented, the reader often lacks the qualifications of intelligence and unprejudiced viewpoint to properly qualify his judgment.

When attacks are made by one group of physicians on another, they can usually be stated briefly and are frequently sensational in character. People are almost always inclined to accept as true any charge made against anyone if it appears in print. Rarely do they have either the opportunity or the desire to fully acquaint themselves with the facts before passing judgment.

Because of this, this past year's tendency of various groups in medicine to be at each others throats through lay media, there has been a reduction of confidence by many lay people in the whole profession. By resorting to the public press instead of channels within the profession, such enthusiasts have ruffled feelings and probably postponed the day when the causes they espouse will receive a dispassionate evaluation from the profession itself. This is bad for both their own views' acceptances and for the benefits to the public which might result.

Overlooked, too, has been the fact that the American public does not distinguish between doctors of medicine. Insofar as their confidence is shaken by unwise public airing of controversy by the profession, it is shaken with regard to all physicians. So, even when they may be right, doctors who carry their criticism to the press instead of to their colleagues are damaging themselves as well as others.

"They have sown the wind, and they shall reap the whirlwind."

Let us hope that we will soon see the end of this dangerous practice, and the full utilization of the channels of medicine itself to properly evaluate such views.

KSMA AND THE RURAL HEALTH CONFERENCE

Among the numerous ways in which the Kentucky State Medical Association directly and indirectly serves the people, few have created the special public favor enjoyed by KSMA sponsorship of the annual Kentucky Rural Health Conference.

The occasion of the third such conference in Louisville, March 10 and 11, justifies an examination by every physician of his proper relationship to such conferences and their primary objective, which is promotion of the Rural Health Council Movement in Kentucky.

The Rural Health Council Movement is predicated on three valid assumptions:

(1) that the highest level of health depends ultimately on the people, themselves,
(2) that creation of an environment conducive to good health is essentially a local responsibility, and
(3) that it can be best achieved through voluntary, cooperative effort embracing all worthy segments of community life.

It has been emphasized through the Rural Health Council Movement that there is a big difference between medical care and health. We physicians have an obviously primary responsibility in good medical care, which is in the last analysis a purchasable commodity. Health is, of course, everybody's business.

Where local rural health councils have been successfully organized, they have served to focus the attention of all community leaders on those aspects of good health which are not strictly the province of professional people. Through their work, individual communities have been able to do a better job in many projects which have a bearing on good health.

Among these have been such widely varied activities as fund-raising for hospital construction, encouragement of better individual eating habits, promotion of individual eating habits, development of good recreational facilities, and such special programs as the blood-donor campaigns.

In some communities the rural health councils have, as such, undertaken projects. In all, however, the idea of using the council as a means for counseling together has created a better lay understanding of community health problems.

And where does the physician fit in this picture? Indeed, where does he fit?

The physician is more than a source of medical care. The layman recognizes him as an authority on all health questions. If he participates as an advisor and member of the community rural health council, the chances of that council consistently going in the right direction are good.

The layman respects his judgment in health matters and appreciates his help. All of us know of many things in our own communities about which our lay friends can do something. They want to do something. But it is important that what they do is sound.

The physician should not be expected to do the work of the rural health council. After all it is a lay movement. If he does not participate, however, he can not blame the laymen for any mistakes which they, in consequence, may make.

Every one of us should be eager to help because we are members of the community. The fact that we are also physicians only emphasizes our responsibility.

We should encourage the interest of our own rural leaders in forming local rural health councils because they can serve the community well. At the same time, we have a responsibility to all the people to also participate ourselves so that our special knowledge and training may temper to layman's enthusiasm and energy.

It is difficult for us to either properly encourage the formation of rural health councils or advise them after their formation if we, ourselves, are not fully conversant with the aims and objectives of the Rural Health Council Movement.

The 1954 Kentucky Rural Health Conference in Louisville, March 10 and 11, affords such an opportunity. You are urged to attend so that you can better understand this fine project of your Association.

President's Page

Guest Contribution

Why was the Rural Health Movement begun in 1945? Because a few citizens recognized that something must be done to better rural health. Rural physicians had decreased at an alarming rate and the "back-bone" of our national economy, the farmer and his family, were not getting the medical care of a level which was available for his urban friend. The AMA got into this rural health business in response to an invitation from the American Farm Bureau Federation. No one group could find the answer to the problem but each individual could contribute his or her part with help and guidance of each individual rural physician.

Success of the Kentucky Rural Health Movement depends to a great extent on the interest, understanding and assistance of every rural physician of the Kentucky State Medical Association. When a farm bureau member, a Kentucky PTA member or Kentucky home-maker asks questions about what can be done to establish a rural health council in their community, they expect and deserve unselfish assistance from the medical profession. The answer to governmental medicine is in the hands of the local family physician. No American physician is a Doctor of Medicine alone, but rather he is a citizen-physician and has definite community responsibilities. The Rural Health Movement is a citizen-community responsibility and that includes you. "Let's put more 'U' in community."

Wyatt Norvell, M.D., New Castle
Vice-President, Eastern Kentucky

It is a real pleasure to share this page this month with one of our vice-presidents, Dr. Wyatt Norvell of New Castle, who has a timely message on the Rural Health Conference in which he is so vitally interested. You are urged to give careful consideration to his comments. In subsequent issues of the Journal you will hear from Dr. R. O. Joplin and Dr. Leon Higdon.

Next month there will be a meeting of the officers of the various county societies. Everyone is invited to attend. Much profitable information will be given—more than enough to repay one for the time and effort required for attendance.

This would seem to be an appropriate time to express to all county society officers in general and the secretaries in particular, our thanks and appreciation for the work they do. Especially is the collection of the annual State and AMA dues an arduous task. It has been well done this year and with the funds now coming in, the necessary and effective activities of the Kentucky State Medical Association can be properly financed. The accomplishment of these objectives will primarily benefit the health of our citizens and indirectly obtain for us the pleasant relationship engendered by those services.

J. Duffy Hancock
President

ORGANIZATION SECTION

Fourth Annual Co. Society Officers Conference, April 15 In Lexington, to Feature AMA Pres.-Elect Dr. Martin

Six Others to Speak at Phoenix Hotel; Doctors Hancock, Sparks Will Preside Over 2 Sessions

Presentations of broad practical appeal by top-flight nationally recognized specialists will be the order of the day at the Fourth Annual County Society Officers Conference to be held Thursday, April 15, 1954, at the Phoenix Hotel in Lexington.

According to KSMA president, J. Duffy Hancock, M.D., Louisville, who made the announcement, the county medical society officers, county committee chairmen, along with state councilors, state committee chairmen and officers will find this among the most profitable sessions yet held.

In addition to the AMA President-Elect Walter B. Martin, M.D., of Norfolk, Virginia, the conference will feature such outstanding personalities as Louis M. Orr, M.D., Orlando, Florida; Percy E. Hopkins, M.D., Chicago; Frank E. Wilson, M.D., Washington, D. C.; Arthur J. Roser, M.D., Fort Wayne, Indiana; Richard S. Graves, M.D., Dayton, Ohio, and Mr. Arthur Tiernan of Evansville, Indiana.

Other features include a panel, "How My County Society Does It," by members of the KSMA who have distinguished themselves in their local county medical society service. Participants will hail from Pikeville and Paducah, Covington and Bowling Green, Lexington and Louisville. The Executive Secretary of the Student AMA, Russell Staudacher, will give a five-minute explanation of student activity.

"Government Medicine, VA Style" will be the subject discussed by Dr. Orr, long active in organized medicine in the Florida State Medical Association and the American Medical Association. An AMA delegate from Florida, Dr. Orr is chairman of the AMA's committee on government services.

Dr. Hopkins, who has a deep personal interest in voluntary health coverages as a member of the AMA's Council on Medical Service, will speak on the topic, "Should the Medical Profession Support All Forms of Voluntary Health Insurance?" A past president of the Illinois State Medical Association, Dr. Hopkins, at present, is serving three state committee chairmanships and is also Illinois' delegate to the AMA.

"The AMA on Capitol Hill" is the subject of Dr. Wilson's talk. Associated with the AMA Washington office since 1949 and director for the past two years, Dr. Wilson will draw upon his varied and rich experiences in the medical field on the local and national level.

The Allen County Medical Society at Fort Wayne, Indiana, has received wide recognition for its work in developing a better understanding between organized labor and the medical profession. Dr. Roser, who led the effort, will speak on "A Meeting with Labor." A native Hoosier, Dr. Roser is a member of the Labor Liaison Committee of the Indiana State Medical Association, and president-elect of the Fort Wayne Medical Society.

(Continued on page 196)



Dr. Wilson



Dr. Roser



Dr. Graves



Mr. Tiernan

Program

Fourth Annual County Medical Society Officers Conference

Phoenix Hotel, Lexington **Thursday, April 15, 1954**

9:15 A. M. Pre-meeting showing of movie

MORNING SESSION

Fireside Room

J. Duffy Hancock, M.D., presiding

President, Kentucky State Medical Association

9:45 **Call to Order and Announcements.** Dr. Hancock

9:50 **Welcome and Remarks.** Rankin Blount, M.D., President, Fayette County Medical Society

9:55 **Greetings from the Headquarters Office.** Bruce Underwood, M. D., Louisville, Secretary and General Manager, KSMA

10:00 **"The M.D. as a Public Speaker"**
Richard S. Graves, M.D., Dayton, Ohio
County Public Relations Chairman

10:20 **"The AMA on Capitol Hill"**
Frank Wilson, M.D., Washington, D. C.,
Director, AMA Washington Office

10:45 **"A Meeting With Labor"**
Arthur J. Roser, M.D., Fort Wayne, Indiana
President-Elect, Fort Wayne Medical Society

11:05 **Intermission**

11:10 **"The County Society Presents the Medical Forum"**
Arthur P. Tiernan, Evansville, Indiana
Executive Secretary, Vanderburg County Medical Society

11:35 **"How My Society Does It"** (Panel of five KSMA County Society Officers)
Jean Clos, Executive Secretary
Jefferson County Medical Society, Moderator

12:00 **Discussion**
J. Farra Van Meter, M.D., Lexington
Chairman of the Council

12:30 **LUNCHEON SESSION, BALL ROOM**

1:30 **Luncheon Speaker - Ball Room**
Walter B. Martin, M.D., Norfolk, Virginia
President-Elect, American Medical Association

AFTERNOON SESSION

Ball Room

Clyde C. Sparks, M.D., presiding

President-Elect, Kentucky State Medical Association

2:00 **"Should M.D.'s Support All Forms of Voluntary Health Insurance"**
Percy E. Hopkins, M.D., Chicago, Illinois
AMA Council on Medical Service

2:20 **"SAMA—Spanning Medical Education with Medical Practice"**
Russell Staudacher, Executive Secretary
Student American Medical Association

2:25 **"Government Medicine, VA Style"**
Louis M. Orr, M.D., Orlando, Florida
Chairman, AMA Committee on Government Services

2:55 **Discussion and Adjournment**

(Continued from page 194)

Dr. Graves, well-known as a dynamic, young leader in developing public relations programs for county medical societies, will discuss "The M.D. as a Public Speaker." It is expected that Dr. Graves will make a valuable contribution in this field. In addition to being active in medical organizational work, he is regarded as an outstanding urologist.

From all over the nation are coming reports of the value to both the public and the profession of the medical forums. One most successful series was held by the Vanderburg County Medical Society at Evansville, Indiana. Mr. Tiernan, nationally recognized county lay executive, will discuss the Evansville series in "Why the Medical Forum."

OFFICIAL CALL

Special Session

HOUSE OF DELEGATES

Kentucky State Medical Association

To the officers and members of the component societies of the Kentucky State Medical Association. Acting under authority of Chapter Four, Section One of the By-laws of the KSMA, the Council has authorized the president of the association to call a special meeting of the House of Delegates to convene at 3 p. m. at the Phoenix Hotel, in Lexington, Thursday, April 15, 1954.

The meeting is called for the sole purpose to consider the authorizing of a Charter for a state wide component medical society for colored physicians as specified in Chapter Twelve, Section Four of the By-laws. Delegates of record in the Headquarters Office on April 15, the Executive Committee has ruled, will be seated.

Council to Hear Medical Education Discussed Thurs., Apr. 15

The Council of the Kentucky State Medical Association will hold a special meeting immediately after the close of the House of Delegates session, Thursday afternoon, April 15, at the Phoenix Hotel, in Lexington, Council Chairman J. Farra Van Meter, M.D., announced.

The purpose of the meeting, Dr. Van Meter said, is to give groups interested in expanding facilities for educating more physicians in Kentucky an opportunity to discuss the matter with the Council.

The Executive Committee, he pointed out, had voted to invite representatives of groups from Fayette county, Jefferson county, Northern Kentucky, and from those counties which are interested in making teaching centers in smaller hospitals in the state. Each group will be asked to limit its discussion to forty minutes. All KSMA members interested are invited to attend the hearing.

Keen Johnson to Speak March 10 at Rural Health Conference

Keen Johnson, Richmond, former governor of Kentucky, will head a program of some 20 speakers at the 1954 Kentucky Rural Health Conference to be held at the Kentucky Hotel, Louisville, Mar. 10-11, it has been announced by Walter L. O'Nan, M. D., Henderson, chairman of the Kentucky Rural Health Council, and Wyatt Norvell, M. D., New Castle, chairman of Kentucky State Medical Association's Rural Health Committee.



Keen Johnson

Mr. Johnson, who is now a vice-president of Reynolds Metals Company, will be the principal speaker at the conference banquet, to be held at 6:30 p. m., Wednesday, March 10. He spent many years in the newspaper field, serving as publisher and editor of the "Richmond Daily Register" at the time of his election to lieutenant governor in 1935. He served as governor from 1939 to 1943, joining the Reynolds organization immediately at the end of that term.

Other features of the 1954 Kentucky Rural Health Conference, which is jointly sponsored by the Kentucky Rural Health Council and the KSMA, will be a symposium on "Farm and Home Safety," group discussions and speakers on a number of other subjects related to what the layman can do in fostering good rural health.

Dr. Norvell and Dr. O'Nan have each urged that every physician who is able to attend the conference do so, representing as it does one of the major public service projects of the Association.

McDowell Shrine Receives $1,000

The Kentucky Surgical Society has made two annual appropriations with this year's gift totaling $1,000 to the McDowell Home, according to Francis M. Massie, M.D., Lexington, secretary-treasurer of the surgical group.

He states that because of the society's deep interest in the McDowell shrine, substantial support will be continued. The check from Dr. Massie was received in the headquarters office in February.

Councilor Districts 14, 13 and 6 Plan April Meetings

With programs already planned, final details are being added to the scientific and social aspects of the April meetings of the KSMA Councilor Districts 14, 13, and 6, which will be held April 7, April 8, and April 13, respectively, according to reports received in the headquarters office from district councilors.

The First District set the pace for the spring meetings by holding the initial one February 11, at Murray State College. These councilors, planning April meetings along with other councilors, have indicated a strong desire to take advantage of these meetings to further their postgraduate education.

First District Meets Feb. 11, at Murray

Morris Weiss, M.D., associate professor of medicine at the University of Louisville School of Medicine, was the featured scientific speaker at a dinner meeting of the First Councilor District, held February 11, at Murray State College. Twenty-five attended.

Dr. Weiss, a cardiologist, discussed "Observations on Coronary Artery Disease," at the 1954 opening meeting, announced J. Vernon Pace, M.D., Paducah, first district councilor.

C. C. Lowry, M.D., Murray, president of the Calloway County Medical Society, presided over the program which followed the dinner prepared and served by the Home Economics Department of Murray State College.

Counties included in the First Councilor District are: Ballard, Calloway, Carlisle, Fulton, Graves, Hickman, Livingston, McCracken, and Marshall.

April 7 Set for 14th District Meeting

An address by the KSMA President and three scentific discussions on diabetes, pediatrics, and gynecology will highlight the afternoon and evening sessions of the Fourteenth Councilor District to meet April 7, at the Prestonsburg Graded School Auditorium, according to George P. Archer, M.D., Prestonsburg, councilor and presiding officer.

"Opportunities for Service," will be the subject of J. Duffy Hancock, M.D., Louisville, president of the KSMA, featured speaker at the dinner meeting, Wednesday evening at 7 p. m., in the Prestonsburg school cafeteria.

Also on the evening program will be Foster Coleman, M.D., Louisville, formerly of Pikeville. "Diagnosis and Management of Diabetes Mellitus" is Dr. Coleman's topic.

John Larson, M.D., Louisville, first speaker of the Wednesday afternoon session beginning at 3 p. m., will discuss "Infant Feeding in the Prevention and Treatment of Disease." A paper on "Office Gynecology—Diagnosis and Treatment" will be presented by Robert Long, M.D., Louisville. Following the afternoon session there will be a social hour from 5:30 to 7 p. m. at the Eagles Club.

Symposium Planned by 13th District

A symposium on "Diseases of the Chest" will be presented by the staff of District Four State Tuberculosis Hospital, Ashland, under the supervision of W. Duane Jones, M.D., at the opening session of the Thirteenth Councilor District Meeting, April 8, 1954, it has been announced by Charles B. Johnson, M.D., Russell, councilor.

He added that the program consists of a morning, afternoon and evening session, beginning with the symposium at 10:30 a. m., Thursday, at the hospital. Dr. Jones will discuss "Chemotherapy of Pulmonary Tuberculosis." Two members of the hospital staff, Robert J. Dancey, M.D., and Nathan Levene, M.D., will present "Diagnosis of Chronic Diseases of the Lung," and "Segmental Resection in Thoracic Surgery," respectively.

First of three featured speakers at the afternoon session to be held at the Henry Clay Hotel, Ashland, will be George W. Pedigo, M.D., Louisville, who will present a paper on "Management of Coronary Occlusion." "Intestinal Obstruction" will be the subject of Rudy J. Noer, M.D., Louisville, professor of surgery, University of Louisville School of Medicine.

Rounding out the afternoon program will be R. Arnold Griswold, M.D., associate professor of surgery, University of Louisville School of Medicine, speaking on "Trauma of the Hand."

J. Duffy Hancock, M.D., Louisville, president of the KSMA, will speak on "KSMA Opportunities" at the dinner, Thursday evening, beginning at 6:30 p. m. Boyd County Medical Society will act as hosts. A representative from Blue Cross-Blue Shield will discuss "Voluntary Health Insurance."

Sixth District to Meet April 13, Franklin

The Kentucky Heart Association will present the program for the meeting of the Sixth Councilor District, April 13, 1954, according to L. O. Toomey, M.D., Bowling Green, councilor.

He added that the program would be arranged in conjunction with a dinner at the Frank-

lin Country Club, Tuesday evening April 13th. At press time, details on the Sixth District were not all completed, but Dr. Toomey indicated that each member of his district would receive complete details of the program at an early date.

The Sixth District consists of 11 counties: Adair, Allen, Barren, Butler, Cumberland, Edmonson, Logan, Metcalfe, Monroe, Simpson, and Warren.

OB-GYN to Feature Georgia M.D. April 2-3, in Frankfort

Robert B. Greenblatt, M.D., professor of endrocrinology, University of Georgia School of Medicine, will be the featured guest speaker at the seventh Annual Meeting of the Kentucky Obstetrical and Gynecological Society to be held at the Capitol Hotel, Frankfort, April 2-3, 1954.

George McClure, M.D., Danville, secretary of the Kentucky OB-GYN Society, who made the announcement, said that all requests for reservations should be directed to Joseph Liebman, M.D., 215 West Third Street, Frankfort. Dr. Liebman is the Chairman of Arrangements.

The complete program is as follows:

PROGRAM

Kentucky Obstetrical and Gynecological Society

Seventh Annual Meeting

Capitol Hotel **Frankfort**

April 2, 1954

10:00 **Executive Committee Meeting**

10:30 **Registration**

12:00 **Luncheon**

(1) **Functional Uterine Bleeding**
Robert B. Greenblatt, M.D., Augusta, Georgia

(2) **Use of "Acrizane" in Treatment of Moniliasis**
Harold D. Priddle, M.D., Paducah

(3) **Postpartum Hemorrhages**
W. H. Parker, M.D., Owensboro

(4) **Report of Committee on Maternal and Fetal Mortality**
Vernon E. Masters, M.D., Louisville

(5) **Annual Business Meeting**

7:00 **Dinner (members, wives, guests)**
Speaker: Honorable Charles O'Connel, Secretary of State

April 3, 1954

9:30 (1) **Radiation Dosimetry in Treatment of Cervical and Endometrial Carcinoma**
John Meredith, M.D., Scottsville

(2) **Louisville General Hospital Resident Program:**

(a) **Post Menopausal Vaginal Bleeding**
David C. Groenig, M.D.

(b) **Abruptio Placenta - Five Year Survey**
A. Stark Wolkoff, M.D.

(c) **Management of Prolapsed Cord**
Joseph Schultz, M.D.

(3) **A Pathologist Looks at the Vulva**
B. N. Carle, M.D., Paducah

12:00 **Luncheon**

(1) **The Adrenogenital Syndrome**
Robert B. Greenblatt, M.D.

(2) **Ovarian Malignancies, a Five Year Survey at Louisville General and Baptist Hospitals**
J. B. Marshall, M.D.

(3) **Round Table Discussion**

2:00 **Adjournment**

Post-graduate Program Held at Cumberland Falls

Three KSMA physicians highlighted the Post-graduate program presented by the Academy of General Practice and the University of Louisville School of Medicine, February 10, 1954, Cumberland Falls, Kentucky.

W. O. Johnson, M.D., Louisville, was first on the scientific program, speaking on "Management of Vaginal Discharges," followed by Alfred B. Loveman, M.D., Louisville, whose topic was "Common Cutaneous and Mucous Membrane Lesions of Interest to the General Practitioner," illustrated by slide demonstrations.

Ky. Academy of General Practice Holds 3rd Meeting, April 21

The third annual meeting of the Kentucky Chapter of the American Academy of General Practice will be held April 21-22, 1954, at the Netherland Plaza Hotel, Cincinnati, Ohio.

Keith P. Smith, M.D., Corbin, president, will preside over the first scientific session and also at the Annual Subscription Dinner at 7:00 p.m., April 21. A humorous speaker, Ollie James, columnist for the "Cincinnati Enquirer," will be presented at the dinner.

The University of Cincinnati College of Medicine will present the scientific program at the second session, April 22, with Garnett J. Sweeney, M.D., Liberty, president-elect, presiding.

Following is the complete program:

PROGRAM

KENTUCKY CHAPTER OF THE AMERICAN ACADEMY OF GENERAL PRACTICE

NETHERLAND PLAZA HOTEL

Cincinnati, Ohio **April 21-22, 1954**

April 21

Keith P. Smith, M.D., Corbin, presiding

8:00 Registration

9:00 "Trends in Abdominal Surgery"
George Crile, Jr., M.D., Cleveland Clinic

10:00 Visit Exhibits

10:30 "Treatment of Hypertension"
Irvin H. Page, M.D., Cleveland Clinic

11:30 "Medical and Surgical Treatment of Cirrhosis of Liver"
Surgical - Thomas W. McElhinney, M.D., Covington
Medical - Carl W. Kumpe, M.D., Covington

12:30 Lunch with Discussion Period, Visit Exhibits

2:30 "Newer Treatments of Peptic Ulcer"
James O. Ritchey, M.D., Professor of Medicine, Indiana University, Indianapolis

3:30 Visit Exhibits

4:00 "Obstetrical Helps"
C. O. McCormick, Sr., M.D., Professor of Obstetrics and Gynecology, Indiana University, Indianapolis

5:00 Adjournment

7:00 Annual Subscription Dinner

April 22

University of Cincinnati College of Medicine

Garnett J. Sweeney, M.D., Liberty, presiding

8:30 Registration

9:00 "Prevention and Treatment of Eclampsia"
Stanley Garber, M.D.

10:00 Visit Exhibits

10:30 "Diagnosis and Treatment of Complication of Diabetes"
(Diabetic Acidosis, Atherosclerosis, Infections)
Harvey Knowles, M.D., and staff of Metabolism Laboratory

11:30 "Diagnosis and Treatment of Blood Dyscrasias"
(Anemias, Thrombocytopenic Purpura)
Richard W. Vilter, M.D., and staff of Hematology Laboratory

12:30 Lunch with Discussion Period, Visit Exhibits

2:30 "Treatment of Injuries to the Hand"
Vinton E. Siler, M.D.

3:30 Visit Exhibits

4:00 "Gamma Globulin and its Effects on Infectious Diseases"
(Poliomyelitis, Measles, Infectious Hepatitis)
John Allen, M.D., and Harry Shirkey, M.D.

5:00 Adjournment

Nominating Committee to Convene April 15, in Lexington

The Nominating Committee of the Kentucky State Medical Association to select nominees for 1954-55 association officers, will hold its first meeting at 12:30 p. m., April 15, in the Ballroom of the Phoenix Hotel, Lexington.

Members of the KSMA Nominating Committee include: Marion F. Beard, M.D., Louisville; Howell Davis, M.D., Owensboro; Carl Fortune, M.D., Lexington, John S. Harter, M.D., Louisville, and T. O. Meredith, M.D., Harrodsburg.

The session will be held in connection with the luncheon meeting of the Fourth Annual County Society Officers Conference. A special table will be reserved at the conference luncheon for the Nominating Committee to meet and organize.

According to Chapter V, Section 5 of the KSMA by-laws, the Nominating committee will submit a written report, containing one or more names for each officer to be selected, before the first meeting of the House of Delegates. Each year at the last session, the House selects by ballot five members to serve on the Nominating Committee from a list of ten names submitted by the Speaker of the House.



Shown above is a portion of the record attendance at the Annual Dinner Meeting of the Jefferson County Medical Society, Kentucky Hotel, January 18, 1954, as tellers were collecting ballots.

AMA President-Elect, Dr. Martin, Speaks in Louisville

"Voluntary health insurance coverage in rural areas lags far behind industrial sections of the country," said Walter B. Martin, M.D., Norfolk, Virginia, president-elect of the AMA, addressing the Annual Dinner Meeting of the Jefferson County Medical Society, January 18, 1954, Kentucky Hotel, Louisville.

Educating citizens to the importance of such insurance and encouraging health insurance companies to provide coverage for new types of insurable groups were two suggestions he made for helping persons with low incomes to meet their medical bills.

Commenting on various subjects, Dr. Martin pronounced fee-splitting "ethically wrong and criminal." He upheld the AMA's stand on hospitalization care of veterans which states that only veterans with service connected disabilities, tuberculosis or mental illness should be admitted to Veterans Administration Hospitals.

At the business meeting following Dr. Martin's address, David Cox, M.D., Louisville, was installed as president, succeeding Arthur T. Hurst, M.D., Louisville. Gradie Rowntree, M.D., Louisville, was named president-elect.

Daniel G. Costigan, M.D., Louisville, took office as the new secretary of the society and William C. Buschemeyer was installed treasurer.

More than 225 persons attended the society's Annual Dinner Meeting, the largest number ever to assemble for this event, according to veteran observers.

Henderson Co. Starts TV Films as Public Service Feature

"Preface to Life," an educational medical film, was the latest feature in a series of television programs started under the sponsorship of the Henderson County Medical Society in cooperation with station WEHT, Henderson.

Darrel L. Vaughn, M.D., society president, who made the announcement, added that this was a type of opportunity for public service that a smaller society rarely encountered.

"The project has proved successful," he said, "because of the wholehearted cooperation between Henderson's public health minded television station and members of our society who have taken an active interest in this phase of public relations."

Each film is reviewed by a member of a committee composed of the following physicians: Walter L. O'Nan, G. W. White, John C. Rogers, Charles C. Kissinger, and George A. Buckmaster.

Scientific Exhibitors Urged to Apply Now for Space

Prospective exhibitors should apply now for scientific exhibit space at the 1954 Annual Meeting of the Kentucky State Medical Association, September 21-23, 1954, in Louisville, by filling out and mailing in the form on page 208 of this issue of the Journal.

Everett L. Pirkey, M.D., Louisville, chairman of the KSMA Committee on Scientific Ex-

hibits, made the announcement, and added that elevation of the quality of the exhibits and stimulation of interest on the part of the membership of the KSMA were the committee's twin goals for 1954.

Dr. Pirkey urged prospective applicants to utilize and conserve space in planning their exhibits in order that more applications might be accepted. He pointed out that space was somewhat limited.

The deadline set for making application for exhibit space is August 1, 1954. After this date assignments will be made, according to Dr. Pirkey.

Post-graduate Courses Attracted 41,000 M.D.'s in 1953

Over 41,000 practicing physicians in the United States took some form of post-graduate medical course during 1953, revealing that the average physician devotes 83.3 eight-hour days a year to keeping abreast of current medical developments.

This striking figure, determined by the AMA's Council on Medical Education and Hospitals in a recent preliminary study, is based on data compiled from personal visits to more than 220 medical institutions and questionnaires received from a random cross-country sample of 17,000 practicing physicians.

The study discovered that some form, though varied, of organized post-graduate medical course is being offered in every state in the country with the average physician spending $350 per year to attend the courses.

Favorite ways of keeping up-to-date on medical matters include: (1) medical reading, (2) professional contacts, (3) hospital staff meetings, (4) medical society and specialty group meetings on the local, state and national level, (5) post-graduate courses.

Ky. Surgical Society Meets May 15

Plans are now being made in preparation for the scientific program and other features of the Kentucky Surgical Society's next meeting, May 15, 1954, at French Lick, Indiana.

Francis M. Massie, M.D., secretary-treasurer, who made the announcement, said the complete details of the meeting would be carried in the April issue of the Journal of the KSMA. Other officers of the society are W. Vinson Pierce, M.D., Covington, president, and R. Arnold Griswold, M.D., Louisville, vice-president.

KSMA Becomes Member of Allied Medical Service Group

The Kentucky State Medical Association recently became a member of the newly formed Kentucky Council of Allied Medical Services, which held its organizational meeting January 13, 1954, at the Seelbach Hotel in Louisville.

The other four participating associations include: the Kentucky State Association of Registered Nurses, the Kentucky State Dental Association, the Kentucky State Hospital Association, and the Kentucky State Pharmaceutical Association.

A. B. Coxwell, D.M.D., secretary of the KSDA, was elected chairman. Other officers are E. M. Josey, representing the KSPA; Mrs. Cynthia N. Warren, of the KSARN, secretary.

The objectives of the association are: (1) to promote and encourage high professional concepts in all professions; (2) to combine the efforts of representatives of all professions for the attainment of maximum educational and ethical standards; (3) to correlate their common interests and activities in the interest of all the professions, the government and the general public.

KSMA Physicians Participate in Southern Surgical Meeting

Four KSMA physicians discussed scientific papers at a recent meeting of the Southern Surgical Association at the Homestead Hotel in Hot Springs, Virginia. They were: James C. Drye, M.D., Laman A. Gray, M.D., Arnold Griswold, M.D., and J. Duffy Hancock, M.D., all of Louisville.

According to Dr. Hancock, president of the Kentucky State Medical Association, other Kentucky physicians attending the meeting included: B. B. Baughman, M.D., Frankfort; Coleman Johnston, M.D., Lexington; William H. Pennington, M.D., Lexington; Edward H. Ray, M.D., Lexington, and Charles Vance, M.D., Lexington.

Attending Louisville physicians were: Sam Clark, M.D., Ellis Duncan, M.D., Charles M. Edelan, M.D., H. Hart Hagan, M.D., Joseph Hamilton, M.D., Pat Imes, M.D., Frank P. Strickler, Jr., M.D., Malcom D. Thompson, M.D., and Rudolph F. Vogt, M.D.

Rudolph J. Noer, M.D., Louisville, professor of surgery at the University of Louisville School of Medicine, was among the newly elected members selected at the meeting.

Johnson Co. Host to High School Diabetes Drive Helpers

A number of high school students who participated in the Diabetes Detection Drive in Johnson county by performing over 3000 diabetic tests were guests of the society at a regular meeting January 27, 1954, in Paintsville, according to Augustus D. Slone, M.D., secretary.

In all, 16 students took part in the diabetes program this fall, representing four Johnson county high schools. Verne Horn, superintendent of schools, accompanied the students to the meeting and gave a short talk on the cooperation of the schools and the medical societies in the prevention of this disease.

Students who attended the meeting were: Misses Mary Grace Daniels, Judy Sanders, Janet Blanton, Lou Banks, Bonnie Lou Meeks; Billy Castle and Crit Akers.

AMA Annual Meeting Expected to Draw 11,000 M.D.'s to Calif.

The 103rd Annual Meeting of the American Medical Association, June 21-25, in San Francisco, is expected to attract over 11,000 physicians from all sections of the country, who will be taking advantage of the opportunity to observe the newest developments in medicine.

The Scientific Exhibit, presenting more than 200 displays of new treatments and techniques, will provide opportunity for discussion of individual problems with the demonstrators. All scientific and technical features will be located in the convenient Civic Auditorium.

The House of Delegates will convene at the Palace Hotel; general scientific sessions will be held in the High School of Commerce Auditorium. Section meetings, motion picture films, and other features of the Annual Meeting will be held in buildings adjacent to Civic Center. Watch for further details in the Journal of the KSMA.

Dr. Bergner Elected to Office

The Kentucky Society of Anesthesiologists recently named Robert P. Bergner, M.D., Louisville, president-elect at the annual business meeting, Brown Hotel, Louisville.

Three other Louisville physicians also took office. Willard D. Bennett, M.D., was installed as president, Shelton H. Mann, M.D., vice-president, and Fred A. Sawhill, M.D., secretary-treasurer.

Committee to Plan Movie Program

The Committee on Medical Education will assume the responsibility for the development of a Scientific Movie Program which is presented each year during the Annual Meeting of the Kentucky State Medical Association.

The announcement was made by the Committee on Arrangements, Clyde C. Sparks, M.D., Ashland, chairman, following a meeting of the committee in Frankfort on February 4, 1954.

KSMA Golf Committee Selected

Five KSMA members have been appointed to serve on the 1954 KSMA Annual Meeting Golf Committee, announced Clyde C. Sparks, M.D., Ashland, chairman of the Committee on Arrangements.

Clifton G. Follis, M.D., Glasgow, was selected to serve as chairman. Others on the committee are: Joseph H. Humpert, M.D., Covington; Robert C. Long, M.D., Louisville; Sam A. Overstreet, M.D., Louisville, and William C. Wolf, M.D., Louisville.

Industrial Association Convenes

The Industrial Medical Association held a meeting of its Executive Committee and Board of Directors in Louisville, during February, while the Congress on Industrial Health was in session. Edward C. Holmblad, M.D., Chicago, treasurer and managing director, attended, along with Gradie R. Rowntree, M.D., Louisville, director.

Pediatric Course Begins May 6

The Pediatric Post-graduate Course, sponsored by the Kentucky State Medical Association, the University of Louisville School of Medicine and the American Academy of Pediatrics will be held this year at the new Children's Hospital, Louisville, beginning May 6, 1954, and ending June 24, 1954.

The meetings will be held from 9 a. m. to 12:00 noon on the eight consecutive Thursdays. An invitation is extended to all physicians to attend this course, which promises to be one of the best since it was inaugurated. Inquiries should be sent to W. W. Nicholson, M.D., 1974 Douglass Boulevard, Louisville 5, Kentucky.

Pertinent Paragraphs

The Third Annual Seminar and Conference on Cancer Cytology will be conducted by the Cancer Institute at Miami, April 21-24, 1954, announced Joseph S. Stewart, M.D., chairman. Leading authorities on cancer from the U. S. and abroad will speak on all phases of the subject. Demonstrations will be held on the taking and preparation of cytodiagnostic tests showing the latest advances in cancer diagnosis using new blood testing procedures and cytological methods.

The third annual symposium on "Tuberculosis and Other Chronic Pulmonary Diseases for General Practitioners" will be held at Saranac Lake, New York, July 12-16, 1954. The registration fee is $40 for AAGP members and $50 for non-members. Complete information concerning the symposium can be obtained by writing: Richard P. Bellaire, M.D., Chest Disease Symposium, P. O. Box 2, Saranac Lake, New York.

The American Geriatrics Society will hold its 11th Annual Meeting June 17-19, 1954, at the Fairmont Hotel in San Francisco, preceding the meeting of the American Medical Association. Hotel reservations should be made through the San Francisco Convention and Visitors Bureau, 200 Civic Auditorium, San Francisco 2, California.

The Public Relations Department of the American Medical Association reports that a number of writers and advertisers are helping to promote increased understanding and mutual good will among physicians and patients. Medicine's positive story is being told by such devices as public service advertisements such as the one entitled, "How to Select a Family Doctor," scheduled in several current magazines by a cooperative pharmaceutical company.

The 1954 Industrial Health Conference, under the sponsorship of six industrial associations, will be held in Chicago, April 24-30, 1954, at the Hotel Sherman. The registration fee is three dollars. Additional information and a preliminary program are available at the KSMA headquarters office.

The National Gastroenterological Association recently announced that the name of its official publication has been changed from "The Review of Gastroenterology," to "The American Journal of Gastroenterology," effective with the January, 1954 issue. Samuel Weiss, M.D., will retain his position as editor-in-chief.

In certain cases, satisfactory healing of surgical wounds may be obtained without the application of postoperative dressings, it was reported in the Archives of Surgery, published by the AMA. "The concept, widely held since the beginning of the aseptic era of surgery, that dressings aid in preventing bacterial infection may accordingly require alteration," the article stated.

The American Medical Association has authorized a study of the question of group practice which has been on the upswing since World War II. The Council on Medical Service and the American Association of Medical Clinics hope to complete the proposed field project, employing personal interviews, by early fall.

A brief glance at the number of services rendered by the AMA Physicians Placement Service, comparing the last three months of 1953 with the same period in 1952, shows a 95 per cent increase in the number of requests from communities seeking physicians. Also noted was a 130 per cent increase in the number of letters of inquiry from physicians seeking places to locate.

THE FIVE GREAT DANGERS TO MEDICINE

(Continued from page 189)

The future of medicine will only be secure if every physician keeps himself alert to those threatening influences that would undermine or destroy it directly. Dr. Sparks has well stated some of the most important of these. We cannot but agree with him, that the greatest danger is that which comes from within ourselves.

At the risk of laboring both a quotation and a point: "It is the common fate of the indolent to see their rights become a prey to the active. The condition upon which God hath given liberty to man is eternal vigilance; which condition, if he break, servitude is at once the consequence of his crime and the punishment of his guilt."

Washington News Digest

Washington, D. C.—Some parts of the Eisenhower administration's broad health program are making good progress on Capitol Hill, while others are virtually standing still or bogged down in the technical complications that are always a threat to new legislation. Well ahead of the other proposals, and possibly destined for enactment, are bills to broaden the scope of the Hill-Burton hospital construction law and to liberalize income tax deductions for medical expenses.

The House Interstate and Foreign Commerce Committee, under chairmanship of Rep. Charles Wolverton (R., N. J.), wound up its long fact-finding study of voluntary health insurance plans and immediately started hearings on the Hill-Burton changes. The purpose is to amend the Hill-Burton law so that it can be used to disburse federal grants to states for construction of health facilities that do not qualify as "hospitals." The administration is anxious to stimulate the building of more nursing homes, hospitals for the chronically ill, diagnostic or treatment centers and rehabilitation facilities.

An initial appropriation of $2 million would be authorized for surveys and planning, and $60 million annually for three years of construction. Per capita income as well as population would be used to determine a state's share, as under the present Hill-Burton program.

At the House hearing, crowded into two days, the construction program was indorsed at least in principle by every witness, except the representative of the American Association of Nursing Homes. Because the program is limited to non-profit sponsors, members of this group could not receive grants. Their spokesman said long-term loans through the Small Business Administration would help solve their problem.

American Medical Association recommended passage of the bill, but urged that facilities for the chronically ill and the handicapped be "part of or near a conventional hospital," and that facilities of all types be open to the entire community without discrimination, as in the present Hill-Burton law. (It is likely hearings also will be held on this legislation in the Senate.)

The House Ways and Means Committee, meanwhile, was giving its approval to a new income tax provision that would allow the deduction of medical expenses if they exceed 3% of adjusted gross income, rather than 5% under present law. The present maximum limitation would be doubled, and the deduction of travel expenses allowed where travel is prescribed by a physician. These changes—a long-time AMA goal—are embodied in the omnibus tax readjustment bill.

President Eisenhower's proposal for federal reinsurance of voluntary health plans has not been able to follow the steady course on which it first appeared to be embarked. At the House hearings, none of the spokesmen for the large organizations in the health fields—AMA, Blue Cross and Shield, American Hospital Association—was willing to indorse the plan. Like the AMA spokesmen, most of them wanted first to examine the actual administration bill, which at that time had not been introduced. From the Blue Cross, however, came a suggestion that the idea be tried out experimentally.

Spokesmen for national labor organizations expressed mixed reactions, with some maintaining that reinsurance was a poor substitute for what they believe the country really needs —national compulsory health insurance.

The administration's health budget for the next fiscal year, starting next July 1, calls for a slight overall reduction. The regular Hill-Burton program, currently operating on $65 million, would get $50 million (any appropriation to start the proposed expanded construction would be in addition). Relatively sharp reductions would be made in funds for venereal, tuberculosis and communicable disease control, in line with the policy of shifting this responsibility to the states. The various research institutes would receive about what they are now spending.

One of the few new items is for $7.8 million, estimated as necessary for the extra cost of enlarging the federal program of vocational rehabilitation. Legislation authorizing the expansion is awaiting Congressional action. The administration hopes gradually to increase the number of persons rehabilitated annually from the current 60,000 to 200,000. While the program is being stepped up, one of its goals would be to induce states to increase their spending until eventually their appropriations match the federal. Like most of the President's health program, the rehabilitation effort has the support of the AMA.

Conferences between AMA officials and administration leaders are continuing. Latest sessions were with Secretary Hobby, concerning her department's legislative plans; with VA Administrator H. V. Higley, on treatment of non-service connected cases; and with Adm. Arthur W. Radford, chairman of the Joint

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News Items

Vernon Woodard Corder, M.D., formerly of Louisville, has opened an office at 508 N. W. 39th Street, Oklahoma City, Oklahoma. Dr. Corder was graduated from Hahnemann Medical College of Philadelphia in 1944.

Robert W. Lykins, M.D., recently became associated with **Sam Clark, M.D., Willard Bennett, M.D.,** and **James R. Flautt, M.D.,** Louisville, for the practice of anesthesiology. Dr. Lykins, a 1946 graduate of the University of Oklahoma School of Medicine, interned at the United States Naval Hospital, Philadelphia. In 1948, he served a fellowship at Mayo Clinic, Rochester, New York, and later completed a residency in anesthesiology at the United States Naval Hospital, Philadelphia. Dr. Lykins is a diplomate of the American Board of Anesthesiology and a fellow in the American College of Anesthesiology.

William Ray Moore, M.D., state chairman of the American Academy of General Practice Commission on Hospitals, recently attended a regional committee meeting in Atlanta, Georgia. Ideas and suggestions on general practice in hospitals were exchanged at the meeting.

Claude M. Talbott, M.D., is taking a residency in eye, ear, nose and throat at the Veterans Administration and Children's Hospital, Louisville, following his return from service with the United States Air Force. After being graduated from the University of Louisville School of Medicine in 1946, Dr. Talbott interned at Delaware Hospital in Wilmington. He received additional post-graduate training in his field at Tulane University of Louisiana School of Medicine, New Orleans.

Lewis B. Clayton, M.D., recently opened an office at Corbin. Dr. Clayton was graduated from the University of Tennessee College of Medicine, Memphis, in 1948. Formerly, he practiced at Virgie, in Pike county.

Charles C. Paynter, M.D., recently became associated with Harlan Hospital, after his return from the western section of the United States. Dr. Paynter previously practiced in Harlan county from 1927 to 1940. He is a 1908 graduate of the Kentucky School of Medicine.

Thomas Luis Boneta, M.D., formerly of Richmond, recently joined the surgical staff of Clinton County Memorial Hospital in Albany. Dr. Boneta, who was born in Puerto Rico, is a 1937 graduate of Baylor University College of Medicine, Houston, Texas.

Thomas W. Clark, M.D., has opened an office at 622 Fincastle Building, Louisville, for the practice of internal medicine. He was graduated from Baylor University College of Medicine, Houston, Texas, in 1949 and interned at Jersey City Medical Center in New Jersey. Dr. Clark completed a three year residency in internal medicine at Louisville General Hospital in 1953.

Charles Lemuel Tuttle, M.D., recently became associated with the Houston-McDevitt Clinic in Murray, for the practice of obstetrics and gynecology. Dr. Tuttle was graduated from the Boston University School of Medicine in 1941 and interned at Lynn Hospital, Lynn, Massachusetts. He completed residencies at the Massachusetts Memorial Hospital and Fitzsimmons Army Hospital, Denver. Formerly, he practiced in Brunswick, Maine.

John P. Hill, Jr., M.D., recently became associated with the Somerset Clinic, for the practice of urology. After his graduation from Emory University School of Medicine, Emory University, Georgia, Dr. Hill completed his internship and also a residency in urology at Grady Memorial Hospital, Atlanta.

James Black Jones, Jr., M.D., formerly of Verda, in Harlan county, has opened an office in Memphis, Tennessee. His new address is 607 Estridge Drive, Memphis. Dr. Jones was graduated from the University of Tennessee College of Medicine in 1922 and had been practicing in Verda since 1950.

Everett Gerald Davis, M.D., formerly of Glasgow, is now associated with the Midland Michigan Hospital Association. Dr. Davis began practicing in Glasgow in 1952, soon after his graduation from the University of Louisville School of Medicine in 1950.

County Society Reports

CALLOWAY

The monthly meeting of the Calloway County Medical Society was held in the chapel of the Murray Hospital, January 4, 1954, with C. C. Lowry, M.D., president, presiding.

The following physicians were present: A. D. Butterworth, M.D., Charles Clark, M.D., Robert Hahs, M.D., J. C. Hart, M.D., Hugh Houston, M.D., C. H. Jones, M.D., C. C. Lowry, M.D., O. K. Mason, M.D., J. A. Outland, M.D., Kenneth Ross, M.D., Charles L. Tuttle, M.D., and Dr. Thomison. Karl E. Warming, administrator, was also present.

It was agreed by the society that the minutes of the Calloway County Medical Society be sent to the Journal after they had been read and approved each month.

J. L. Hopson, M.D., Secretary

GRANT

The Grant County Medical Society met at the home of Lenore Chipman, M.D., Williamstown, with O. Abbett Cull, M.D., president, presiding. Other members present were: Smith H. Gibson, M.D., Russell E. Kinsey, M.D., Minnie Virginia Kratz, M.D., Frederick R. Scroggin, M.D., Claude C. Waldrop, M.D. The guest list included: William Temple, M.D., of Covington, Dr. Bowling of Owenton, Dr. Robert Kratz, Mr. Ross Harrison and Mr. Clifford B. Amos, of the Blue Cross-Blue Shield office, and Mr. Everett Chipman.

Mr. Harrison described the origin and growth of voluntary health insurance programs. He discussed the Blue Cross and Blue Shield plans and told of various changes that have been instituted. He advised the members to make complete reports of medical and surgical procedures carried out on patients.

Dr. Temple presented a paper on "Disorders of the Neonatal Period," including erythroblastosis foetalis, hyaline membrane, atelectasis, cerebral hemorrhage, and neonatal infections.

The Society decided that the Mobile Cancer Clinic scheduled for March 3, 4, and 5 be held at the Grant County Health Department. Patients will be referred by the county physicians and the clerk at the Health Office will schedule the appointments.

The medical meeting and dinner to be held in conjunction with the clinic will take place at the Carlsbad Hotel in Dry Ridge on March 3, at 6:30 p.m. Dr. Cull announced that Mrs. J. O. Mattox, vice-president of the KSMA Auxiliary, had requested permission from Grant County Medical Society to organize a local auxiliary. A motion was made that permission be granted. The motion carried.

Dr. Waldrop announced the next meeting of the Licking Valley Medical Society, of which he is president, will be March 11th at the Carlsbad Hotel.

Dr. Gibson moved that an article on what to look for in buying health insurance be published in the local newspaper, as well as subsequent articles on the same subject, which would be inspected and approved by the County Health Officer. The motion carried.

Virginia Kratz, M.D., Secretary

JOHNSON

The regular meeting of the Johnson County Medical and Dental Society was held January 26, 1954, in Paintsville. The following physicians and dentists were present:

D. H. Dorton, Jr., M.D.; Lon C. Hall, M.D.; Paul B. Hall, M.D.; Robert A. Hall, M.D.; Howard Meade, D.M.D.; Harry T. Overby, M.D.; Charles Preston, M.D.; G. P. Salyer, D.D.S.; A. D. Slone, M.D.; G. V. Stafford, M.D.; T. E. Walden, M.D., and A. F. Williams, D.M.D.

Verne Horn, superintendent of the Johnson county schools, and a number of students who helped the society make diabetes tests during detection week were guests.

At the business session, Dr. Lon Hall was elected president, Dr. Dorton, vice-president, and Dr. Slone, secretary-treasurer.

The society voted affirmatively to request the return of the Cancer Mobile Clinic to Johnson county in 1954. Providing glasses for the indigent students in the county was passed and the problem of who is to receive them was left to the discretion of Dr. Slone and Dr. Walden.

Augustus D. Slone, M.D., Secretary

LETCHER

The following officers were elected by the Letcher County Medical and Dental Society at the regular monthly meeting, December 26, 1953: Bert C. Bach, M.D., president; Lee Moore, D.D.S., vice-president; Owen Pigman, M.D., secretary-treasurer.

In addition to the elected officers, R. Dow Collins, M.D., and Carl Pigman, M.D., also attended the meeting held in Whitesburg. Appointment of committees will take place at the next meeting.

Owen Pigman, M.D., Secretary-Treasurer

McCRACKEN

The monthly dinner meeting of the McCracken County Medical Society was held January 27, with W. K. Sloan, M.D., presiding.

Robert Lich, M.D., professor of urology, University of Louisville School of Medicine, discussed "The Kidney, Fluids, and Electrolytes," on the scientific program. He was introduced by O. D. Maxey, M.D.

James Carl Embry, M.D., was admitted as a new member of the society. Letters of application from H. J. Strieder, M.D., and B. F. Bradford, M.D., were read.

Correspondence from the "Paducah Sun-Democrat" was read concerning the success of the Medical Forum. Coles Raymond, M.D., moved that the society continue the forum, the extent of which to be determined by the public relations committee.

It was moved that members of the First Councilor District be invited to attend the society's April meeting and consider it a district meeting.

Appointment of committees was as follows:

Legislative: Leon Higdon, M.D., R. W. Robertson, M.D., Walter Johnson, M.D.,

Grievance: Harold Priddle, M.D., W. P. Hall, M.D., Eugene Sloan, M. D.,

Voluntary Medical Insurance: D. Y. Keith, M.D., Coles Raymond, M.D., W. B. Haley, M.D.,

Program: O. D. Maxey, M.D., James Ward, M.D., Walker Turner, M.D.,

Public Relations: Walter Johnson, M.D., H. S. Gardner, M.D.,

Emergency Medical Service: George Widener, M.D., Walker Turner, M.D., Winfield Stryker, M.D.

Library: Eugene Blake, M.D., W. B. Haley, M.D., Robert Reeves, M.D.,

Rural Health: E. E. Ramey, M.D., R. M. Wooldridge, M.D., Joseph Spaulding, M.D.,

Diabetic Detection: Eugene Sloan, M.D., E. E. Ramey, M.D., Charles Billington, M.D.,

Blood Bank: W. B. Haley, M.D., Vernon Pace, M.D., B. N. Carle, M.D.,

Amplifier: J. E. Dunn, M.D., Casey Purdy, M.D., Charles Billington, M.D.

Dr. Higdon moved that members now serving on the Board of Health continue to serve. The motion carried.

M. W. Fowler, Jr., M.D., Secretary

PIKE

The Pike County Medical Association held its regular monthly meeting on January 19, 1954, at Pikeville. Eighteen members and ten guests were present for the dinner meeting. Guests were Joseph M. Crowley, M.D.; G. H. Hughes, D.D.S.; R. H. Bevins, D.D.S.; W. T. Hatcher, D.D.S.; D. C. White, D.D.S.; J. Adkins, D.D.S.; W. O. Allen, D.D.S., and Mr. Gailhouse, Mr. Foulkes and Mr. Distad, externs from the Pikeville Methodist Hospital.

The dentists were invited to discuss the feasibility of having them as associate members. All present agreed that medical and dental problems were closely allied and that joint meetings could be planned to stimulate the interest of both groups. During February, the dentists will decide whether they will become associate members of the medical association.

T. M. Perry, M.D., Jenkins, and Joseph M. Crowley, M.D., Martin, were accepted as associate members.

William F. Clarke, M.D., led a discussion on the formation of a Chamber of Commerce in Pike County and the extent to which the Pike County Medical Association should lend support to the plan.

G. N. Combs, M.D., discussed the formation of a Pike County grievance committee. The matter was discussed and tabled until a committee had an opportunity to investigate the accomplishments of other county grievance committees as well as the necessity for a local committee.

T. I. Doty, M.D., and W. C. Gose, M.D., were appointed as a committee to gather information to determine if a few people were abusing charity privileges.

The scientific program on premature contractions and extra systole was presented by Dr. Clarke. Many electrocardiograms were shown demonstrating premature auricular and ventricular premature contractions.

Russell H. Davis, M.D., Secretary-Treasurer

SHELBY-OLDHAM

The Shelby-Oldham County Medical Society met January 28, 1954, at the Old Stone Inn with the following members and guests present: A. C. Weakley, M.D., Don Chatham, M.D., Charles Chatham, D.D.S., L. A. Wahle, M.D., W. P. McKee, M.D., George Ray, M.D., George Perrine, M.D., A. D. Doak, M.D., M. H. Skaggs, M.D., H. H. Richeson, M.D., B. B. Sleadd, M.D., H. T. Alexander, M.D., H. B. Mack, M.D., L. B.

(Continued on page 210)

Application

FOR SPACE IN THE SCIENTIFIC EXHIBIT

1954 Annual Meeting Kentucky State Medical Association

Columbia Auditorium Louisville, Kentucky September 21, 22, 23

Fill Out and Mail to:

EVERETT L. PIRKEY, M. D., *Chairman*
Committee on Scientific Exhibits
Louisville General Hospital,
Louisville 2, Kentucky

---

1. Title of Exhibit: .....
2. Description or nature of exhibit: (Attach brief description to this blank).
3. Will you require shelf space? .....
4. Give approximate amount of wall space needed. (Included in total space is two side walls of two feet in length) .....
5. Name of institution co-operating in the exhibit (if desired) .....
6. Name of exhibitor: .....

..... (Street & No.) ..... (City)

(Deadline for mailing application August 1, 1954)

The Kentucky State Medical Association will provide without cost to the exhibitor the following: Exhibit space, shelves, sign for booth, current, bracket lights.. provided all items are approved in advance by the committee.

Cost of transporting exhibits to the meeting must be borne by the individual exhibitor as well as costs of cards, signs, etc., which are a part of the exhibit.

View boxes, furniture, decorations, etc., may be rented, if desired, by applying directly to Jos. T. Griffin Company, 704 West Main Street, Louisville 2, who supply equipment for the annual K.S.M.A. meeting.

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AUTHORS	No. of Patients	Chronic, Resistant to Other Therapy	TYPES OF ULCERS				RELIEF OF SYMPTOMS (Chiefly Pain)				Surgery or Complications[1]	Side Effects Requiring Discontinuance of Drug[2]	EVIDENCE OF HEALING			
			Duodenal	Jejunal	Stomal	Gastric	Good	Fair	Poor	No Report			Complete	Moderate	None	No Report
Grimson, Lyons, Reeves	100	100	93	7			80	11	4		5		47		19	29
Friedman	15	15	14			1	5		4	6[3]			2			13
Bechgaard, Nielsen, Bang, Gruelund, Tobiassen	26	26	21			5	16	4	6				8	6	12	
McHardy, Browne, Edwards, Marek, Ward	162		162				136	12	11		3	1	14	9	7	129
Segal, Friedman, Watson	34	34	34[4]				14	13			7	2	5		8	14
Brown, Collins	117	99	117				97	7	8		5	8	55	9	8	40
Asher	77		65		7	5	52	9	16			16		9	21	47
Rodriguez de la Vega, Reyes Diaz	5	4	5				4		1					3	2	
Winkelstein	116	116	102	8		6	102		14				53		18	45
Hall, Hornisher, Weeks	18	18	18				11		1	6[5]			18			
Maier, Meili	38	38	24			14[6]	27	7	4[7]				10	2	5	21
Meyer, Jarman	25	18	25				21		4							25
Poth, Fromm	37	37	37				33	3	1				33	3	1	
Plummer, Burke, Williams	41	41	41				36		5				38		3	
McOonough, O'Neil	104	100	104				63	10	31			11	4		11	89
Broders	60	60	58		1	1	35	19	6				10	1	49[8]	
Legerton, Texter, Ruffin	11		11				11									11
Holoubek, Holoubek, Langford	76	69	76				35	27	10		4	10	26		10	36
Ogborn	42		39	2		1	42[9]									42
Shaiken	48	48	48				33	10	3		2		33	10	3	
Johnston	145	145	145				143		2			2	143		2	
Rossett, Knox, Stephenson	146		141			5	146					4[10]	53			93
TOTALS	1443	968	1380	17	8	38	1142	132	131	12	26	54	552	52	179	634
PERCENTAGES		67.8	95.6	1.2	0.6	2.6	81.3	9.4	9.3			3.7	70.5	6.6	22.9	

1. Not included in tabulations.
2. Included in "Relief of Symptoms" as "Poor" and in "Evidence of Healing" as "None."
3. Four had no symptoms when Banthine therapy was begun.
4. Of which seven were penetrative lesions and five partially obstructive.
5. No symptoms were present in four.
6. Two with symptoms only, no demonstrable ulcer.
7. Three were psychopathic patients and one had a ventricular ulcer of the lesser curvature.
8. Roentgen findings after treatment period of two weeks; forty-seven had duodenal deformity.
9. All returned to work within a week.
10. In these four, after relief of symptoms, Banthine was discontinued because of urinary retention.

During the past three years, more than 250 references to Banthine therapy in peptic ulcer and other parasympathotonic conditions have appeared in medical literature. Of these reports, 22 have presented specific facts and figures on the results of treatment in a total of 1,443 peptic ulcer patients, 67.8 per cent of whom were reported as chronic or resistant to other therapy. These results are tabulated above and show:

"Good" relief of symptoms was obtained in 81.3 per cent of the 1,405 patients on whom reports were available.

"Complete" evidence of healing was obtained in 70.5 per cent of the 783 patients on whom reports were available.

In all but 9.3 per cent, relief of pain was "good" or "fair." In all but 22.9 per cent, evidence of healing was "complete" or "moderate."

During treatment, 26 patients required surgery or developed complications other than ulcer which required discontinuance of the drug before results could be evaluated.

Of the remaining 1,417 patients, only 3.7 per cent experienced side effects sufficiently annoying to require discontinuance of the drug.

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*Volume containing complete references, with abstracts of 39 additional reports, will be furnished on request by

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COUNTY SOCIETY REPORTS

(Continued from page 207)

Sternberg, M.D., B. F. Shields, M.D., C. C. Risk, D.D.S., H. T. Ransdell, M.D., A. L. Heise, D.D.S., and Mr. McConnell and Mr. Miles of the Blue Cross-Blue Shield.

Dr. Shields called the meeting to order and introduced Mr. McConnell, who spoke on the work of the Blue Cross-Blue Shield Hospital Plan. Dr. Risk introduced the next speaker, Dr. Ransdell, of Louisville, who spoke on "Intratracheal Suction in the Prevention and Treatment of Pulmonary Disease." His talk was well received and discussed by many present.

C.C. Risk, D.D.S., Secretary

WARREN-EDMONSON

Richard O. Green, M.D., presided at the Warren-Edmonson County Medical Society meeting, January 5, 1954. The program consisted of a discussion by Mr. Monroe Levin on the role of clinical psychology in relation to the practice of medicine.

J. T. Gilbert, M.D., was elected delegate to the Kentucky State Medical Association and Martin Wilson, M.D., alternate delegate. G. H. Freeman, M.D., was presented with an honorary membership in the Warren-Edmonson County Medical Society by the members.

In the future invitations will be extended to the medical societies in Allen and Simpson county in order to improve the advantages of scientific presentations.

Charles M. Francis, M.D., Secretary

In Memoriam

WILLIAM LOUARD CASH, M.D.

Princeton

1880 - 1954

Dr. William Louard Cash, 74, died January 22, 1954, at his home in Princeton, in Caldwell county. A loyal member of the Kentucky State Medical Association, Dr. Cash served a term as vice-president from the Western Section of Kentucky from 1947 to 1948.

A native Kentuckian, Dr. Cash was graduated from the Hospital College of Medicine, Louisville, in 1907, and soon afterwards began practicing in Princeton, where he remained the rest of his life. He was an active member of the Caldwell County Medical Society.

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J. D. STEWART, M.D.

Owensboro

1879 - 1954

Dr. J. D. Stewart, 75, of Owensboro, died during the month of February, 1954. For many years he had practiced in Daviess and Ohio counties. In 1941 he located in Owensboro and practiced there until his death. Dr. Stewart was graduated from the Hospital College of Medicine, Louisville, in 1903.

LOUIS H. MULLIGAN, M.D.

Lexington

1870 - 1954

Dr. Louis H. Mulligan, 84, died February 13, 1954, in Lexington. A native Kentuckian, he attended and was graduated from the Louisville Medical College in 1896. He located in Lexington in 1912 and continued to practice there until his death. Dr. Mulligan was a member emeritus of the Fayette County Medical Society and the Kentucky State Medical Association.

PEPTIC PATHOLOGY

(Continued from page 188)

that same period, have cloaked the field of gastric disorders in a somber shroud of pessimistic resignation. Those times have gone, these attitudes must go. A far keener interest in and a more intensely aggresive attitude toward the dyspeptic will undoubtedly enhance our diagnostic accuracy and thereby tremendously increase our satisfactory surgical results.

WASHINGTON NEWS DIGEST

(Continued from page 204)

Chiefs of Staff, Dr. Frank Berry, Assistant Defense Secretary for health and medical matters, and Dr. Howard A. Rusk, chairman of the Health Resources Advisory Committee, on medical care for military dependents. Representing the AMA at one or more of the meetings were Drs. Walter B. Martin, David B. Allman, Gunnar Gundersen, Louis Orr, James C. Sargent, W. L. Crawford, George F. Lull, Ernest B. Howard and Frank E. Wilson.

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1. Sayer, R. J., et al.: Am. J. M. Sc. *221*:256 (Mar.) 1951.
2. Welch, H.: Ann. New York Acad. Sc. *53*:253 (Sept.) 1950.
3. Werner, C. A., et al.: Proc. Soc. Exper. Biol. & Med. *74*:261 (June) 1950.
4. Wolman, B., et al.: Brit. M. J. *1*:419 (Feb. 23) 1952.
5. Potterfield, T. G., et al.: J. Philadelphia Gen. Hosp. *2*:6 (Jan.) 1951.
6. King, E. Q., et al.: J. A. M. A. *143*:1 (May 6) 1950.

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Regional Epilepsy Group to Meet

Representatives from five states including Kentucky will attend the first Institute on the Social Aspects of Epilepsy to be held in this region, sponsored by the Ohio Society for Crippled Children, March 19 and 20 at the Deshler-Hilton Hotel, Columbus, Ohio.

Walter B. Underwood, executive director of the society, who made the announcement, said the Institute has as its theme, "The Unmet Needs of the Epileptic." There will be no registration fee, and all sessions are open to the public. Complete details of the program may be obtained at the KSMA headquarters office.

BOOK REVIEWS

DISEASES OF WOMEN, 10th Edition, by Robert J. Crossen, M.D., C. V. Mosby, 1953, $18.50.

The price of this publication has increased since the last edition. In spite of this fact, there are 57 fewer illustrations and the chapters, "The Lower Intestinal Tract in Relation to Gynecology" and "Invasion of the Peritoneal Cavity" have been omitted.

In the copy supplied this reviewer there are many unprinted pages, and therefore obviously omitted material. The section on "Endocrine Relations Concerned in the Ovarian Cycle" is by Willard Allen, M.D.

Several pages of reference are devoted to premarital advice, family counseling, etc., and their influence upon psychosomatic and gynecological difficulties.

There is a practical discussion of vaginal smears in the detection of early carcinoma. This text reflects the great changes in the treatment of pelvic infection as a result of the appearance of antibiotics.

A. N. Arneson, M.D., has written the section on "Radiation Therapy."

There is a discussion of carcinoma in situ or pre-invasive carcinoma of the cervix, sometimes called group O lesions, calling attention to the probability that such a diagnosis is quite likely to be insufficient evaluation of the extent of the lesion.

This is not intended to be, and definitely is not, a text of surgical procedures. The sixteen chapters discuss in a clear, informative style, supplemented by the excellent drawings and photographs and photo-micrographs, all the various aspects of gynecology, including the medicolegal ones.

"Diseases of Women" continues to be a leading text of gynecology for both the student and practitioner.

Reviewed by William E. Oldham, M.D., Louisville.

Ten Ways to Kill an Association

1. Don't come to the meetings.
2. If you do, come late.
3. If the weather doesn't suit you, don't think of coming.
4. If you do not attend a meeting, find fault with the officers and members.
5. Never accept an office, as it is easier to criticize than do things.
6. Nevertheless, get annoyed if you are not appointed to a committee. If you are appointed, don't attend the committee meetings.
7. If asked by the chairman to give your opinion regarding some important matter, tell him you have nothing to say. After the meeting tell everyone how things should have been done.
8. Do nothing more than is absolutely necessary. When other members roll up their sleeves and unselfishly use their ability to help things along, howl that the Association is run by a "clique."
9. Hold back your dues as long as possible—better still don't pay at all.
10. Don't bother about getting new members, but if you do, be sure they are grouches like yourself.

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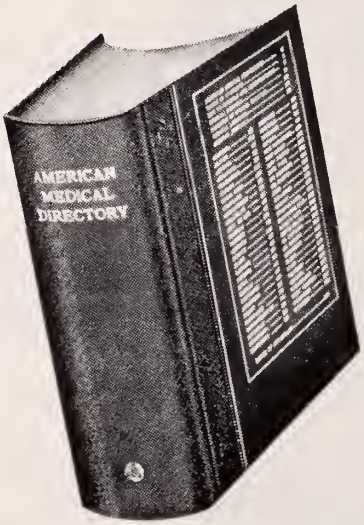
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Albert J. Crevello, M. D.
Diplomate, American Board of Psychiatry & Neurology, Inc
MEDICAL DIRECTOR

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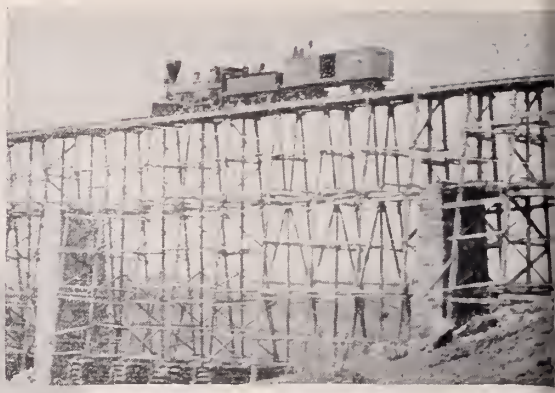
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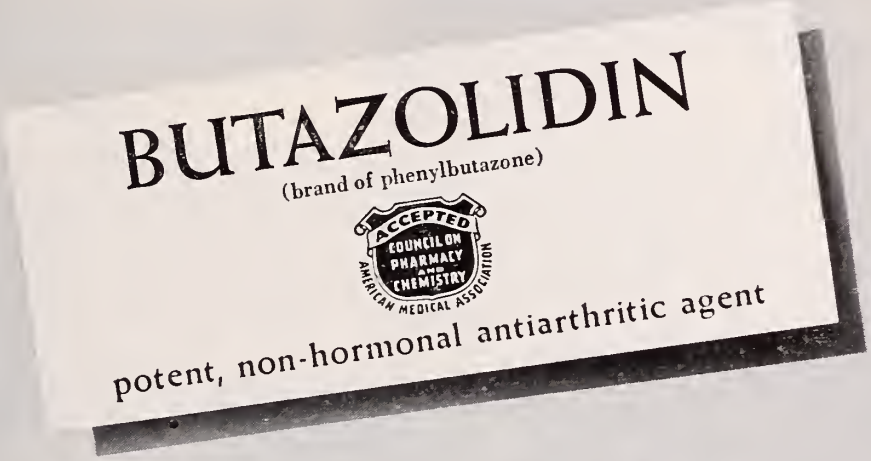
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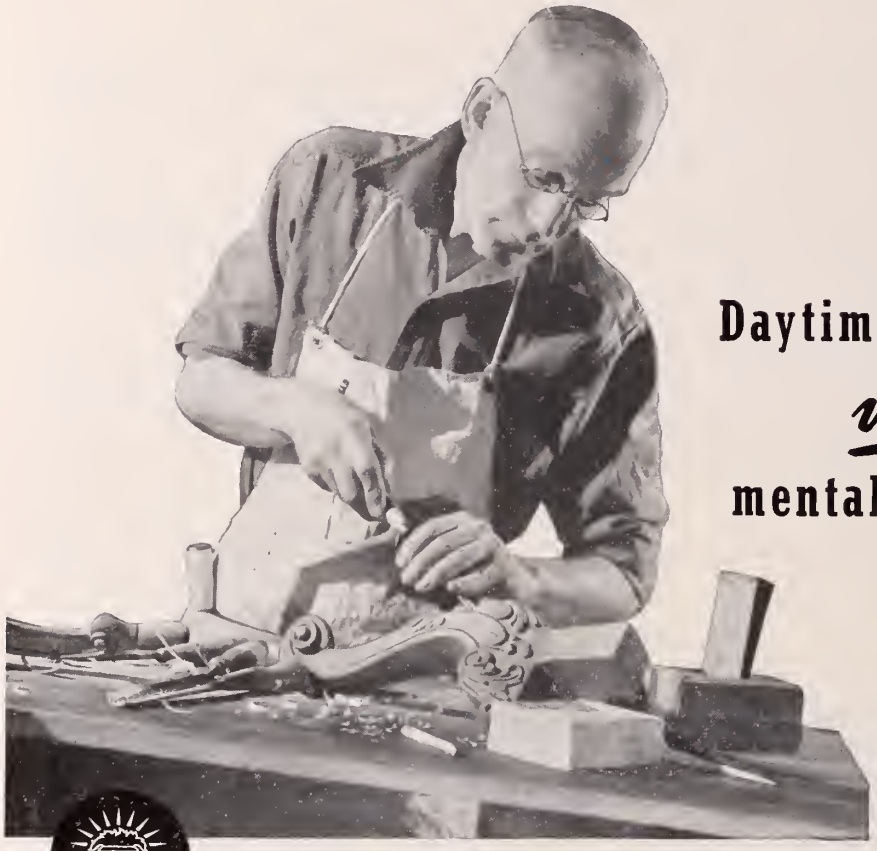
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with
mental alertness

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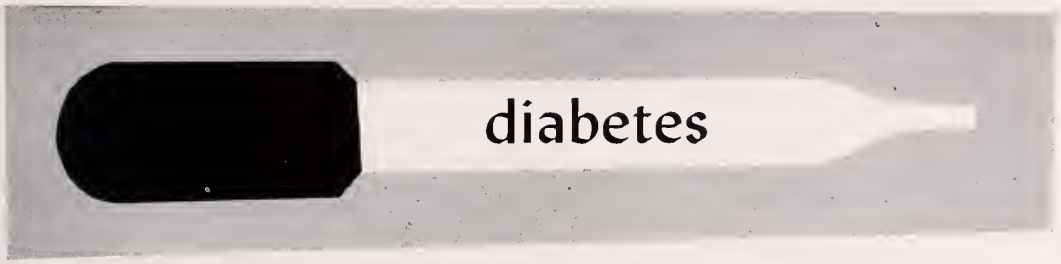
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for detection of urine-sugar

*Data from nationwide poll: Diabetes in daily practice

70% were over 40.
40% had a family history of diabetes.
65% were overweight.

1. Blotner, H., and Marble, A.: New England J. Med. *245*:567 (Oct. 11) 1951.
2. Steine, L.: GP *8*:45 (July) 1953.

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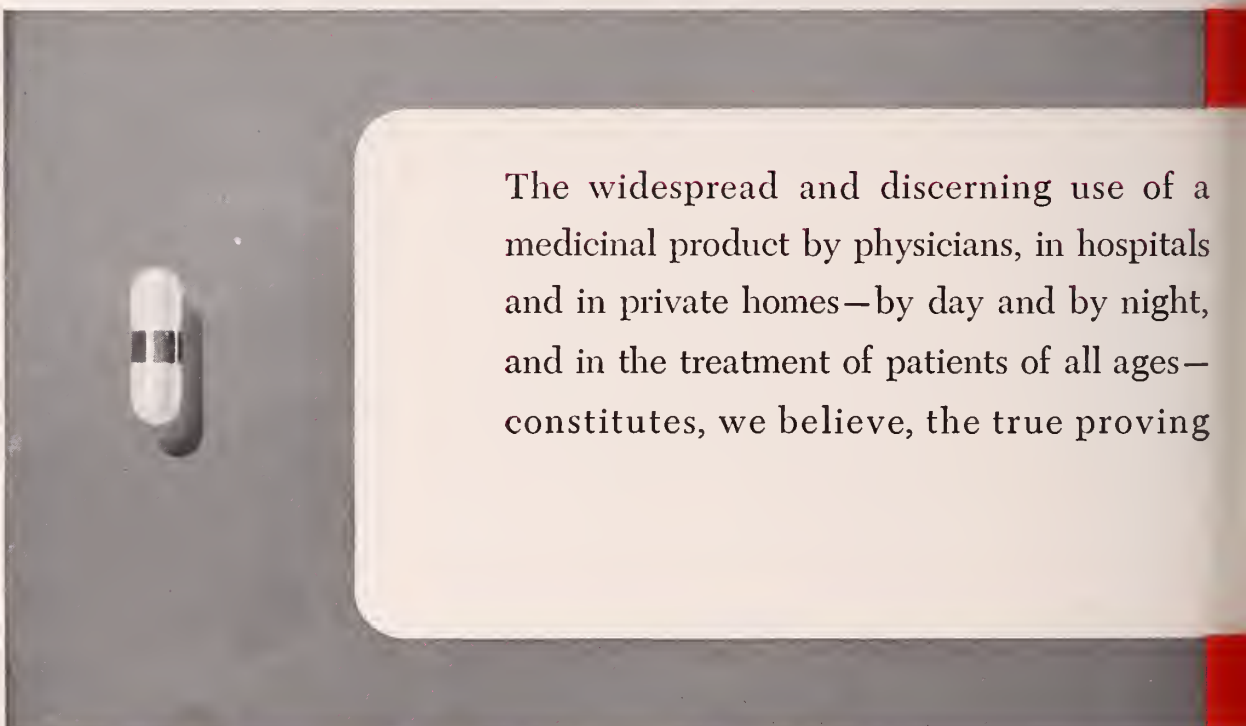
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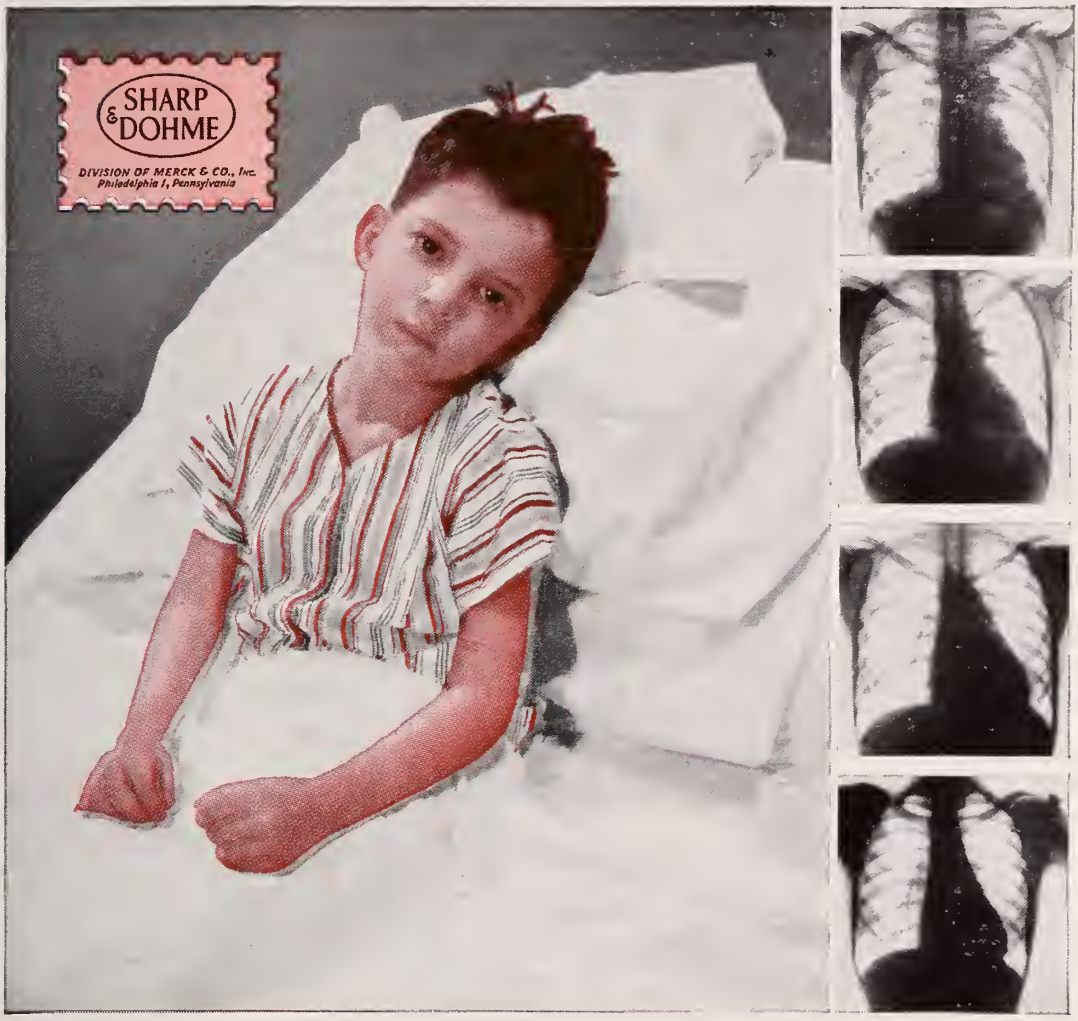
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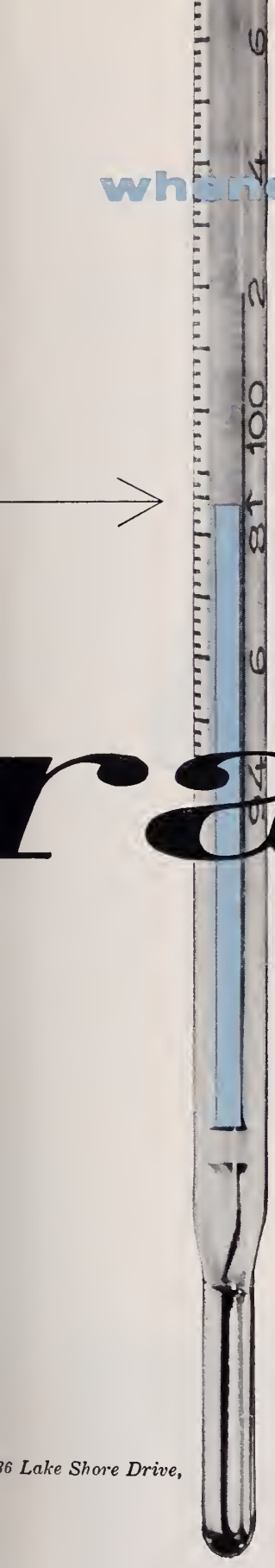
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**English, A. R., et al.: Antibiotics Annual (1953-1954), New York, Medical Encyclopedia, Inc., 1953, p. 70.*

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*Stead, E. A., Jr., in Cecil, R. L., and Loeb, R. F.: Textbook of Medicine, ed. 8, Philadelphia, W. B. Saunders Co., 1951, p. 1065.

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1. Greenblatt, R. B., and Kupperman, H. S.: M. Clin. North America *30*:576 (May) 1946. 2. McGavack, T. H., in Goldzieher, M. A., and Goldzieher, J. W.: Endocrine Treatment in General Practice, New York, Springer Publishing Company, Inc., 1953, p. 225.

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"Terramycin is generally well tolerated...."[4]

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Brand of oxytetracycline

1. Cowart, E. C., Jr.: Mississippi Doctor 29:278 (April) 1952.
2. Sayer, R. J., et al.: Am. J. M Sc. 221:256 (March) 1951.
3. Knight, V.: New York State J. Med. 50:2173 (Sept. 15) 1950.
4. Trafton, H. M., and Lind, H. E.: J. Urol. 69:315 (Feb.) 1953.

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a moderately long-acting Insulin,

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Craniocerebral Injuries

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Craniocerebral injuries appear to be such a widespread surgical problem in our modern United States that it is very doubtful whether the majority of such injuries can be seen at all by the neurosurgeon. It therefore appears not at all amiss to consider the principles of management of such injuries in the light of present day attitudes toward the problem. I should like to emphasize the non-operative management of craniocerebral injuries since I have the distinct feeling that this has been largely neglected in the emphasis that has been placed on the head injuries requiring surgical intervention. This talk will be confined of necessity to management and not to mechanism.

The management of head injuries, as in all illness, depends on accurate diagnosis, and this in turn on the history, the examination, and most especially on clinical neurologic observation.

Proper Transportation

Actually the treatment of craniocerebral or any other injury should begin at the site of the injury, since transportation is such an important matter here. One crying need is for improved instruction for ambulance attendants in the transportation of the unconscious patient. These attendants seem to have been reasonably well indoctrinated with the idea of splinting all fractures before transportation, but it is my distinct impression that we see a great deal too many serious injuries seriously compounded by improper transportation of the patient in coma. The little back rests on the average ambulance litter may very seriously endanger the deeply comatose and profoundly shocked patient with craniocerebral injury by increasing the cerebral damage from hypoxia. This accordingly remains a missionary problem to persuade the ambulance attendant to carry the patient in coma in lateral recumbency with the head flat.

History

In general, the patient is first seen in the emergency room or admission ward of the hospital. The history is many times defective, but none the less, particularly important in injuries of the head. An accurate description of both the injury, the duration of unconsciousness, and subsequent change in consciousness may be of the greatest help, if interpreted with restraint. With the patient unconscious, valuable information relating to variations in the patient's consciousness may at times be obtained from members of the family and should most assuredly be sought, since nothing so clearly indicates the need for serious consideration of surgical exploration as a regression in consciousness.

Examination

The examination itself should be as complete as possible to establish the initial clinical status, the springboard for all subsequent observation in determining improvement or deterioration. In the cooperative patient, the neurologic examination can be quite complete, but in the unconscious one, the vital signs, the state of consciousness, and the condition of the pupils and reflexes can and always must be evaluated. All these signs must be reexamined at frequent intervals. We feel that the state of consciousness itself, and its direction of change, are the signs of the most importance in diagnosing a complicating hemorrhage of surgical significance.

Read before the Kentucky Surgical Society, May 16, 1953.

The question of X-ray examination of the head in the immediate diagnosis of the acutely injured patient nearly always arises, and I suspect that the commonly observed tendency of the house officer to demand immediate X-rays of the skull is simply a reflection of the drive to do something in those patients in whom it is not obvious there is something to be done.

In the patient who is not seriously injured, we generally allow immediate X-ray examination since it simplifies matters considerably, and because many families worry about the X-ray findings. In the critically injured patient, we feel that it is much better to defer X-ray examination in order to spare him unnecessary handling and manipulation, unless it is obvious that he has a compound depressed fracture requiring immediate surgical attention or is suspected of having epidural hemorrhage. The emergency X-ray with a restless confused patient is rarely of diagnostic quality and in the critically injured, the undue activity is inadvisable. In general, the decision for surgical intervention, excepting the depressed fracture, is one made on a clinical basis rather than on an X-ray diagnosis.

Lumber Puncture

Lumbar puncture in the immediate diagnosis of the acute craniocerebral injury is generally of very little value. In the mildly injured patient in whom hospitalization is resisted, the finding of a bloody spinal fluid will generally save the patient a good deal of delayed discomfort by indicating hospitalization for the proper management. When the patient is critically injured it may possibly be dangerous and can add very little to the diagnosis except that when the initial diagnosis of intracranial hemorrhage stands in some doubt, the establishment of an accurate and reliable spinal fluid pressure level may be an important part of the initial examination, from which subsequent rises in measured intracranial pressure may attain some significance. The lumbar puncture in "fighting coma" is not worthwhile.

Associated Injuries

Associated injuries are very frequently found in a patient with a severe head injury. Severe hemorrhage, profound shock and thoracic injuries that embarrass the respiration, not only demand immediate attention for themselves but constitute a prime step in the proper management of cerebral injury, that is, oxygenation. A mild impairment of the sensorium from cerebral injury can be greatly magnified by a serious thoracic injury. Shock, as always, demands the first and most immediate attention, whatever its origin. It has been said by some that serious shock is not an accompaniment of cerebral injury per se without other associated trauma, but we believe that cerebral injury alone can cause very severe shock in the ordinary surgical sense and demands immediate corrective measures of the same type. Immediate transfusion is desirable and such stop gap measures as are generally employed can be safely used in the interim until blood transfusion itself can be started. No surgical treatment of any sort is undertaken until the patient has been relieved of shock.

One other item relative to the effect of other injuries on the management of the head concerns fat embolism from associated fractures of the long bones. It has been repeatedy forced on our attention and, since the classic syndrome of fat embolism from fractures of the long bones, without any cerebral injury, presents cerebral symptoms after a period of two to three days, it may simulate a complicating intracranial hemorrhage. Pure cerebral fat embolism generally causes no increased intracranial pressure and usually the pupils are normal, the spinal fluid free of blood. We have observed patients become worse under the influence of showers of fat emboli incident to increased motion of a fracture and probably incident to the use of paraldehyde. We have abandoned the use of paraldehyde as a sedative in cases that have associated fractures of long bones.

Scalp Injuries

Head injuries may be separated for convenience of discussion into four groups: that is, injuries of the scalp, the skull, the brain and the complicating intracranial hemorrhage. I mention injuries of the scalp only to emphasize the fact that they should not be treated casually. The patient whose small depressed fracture is illustrated was diagnosed as having a scalp laceration, sustained when struck with a bottle, was sutured in an emergency room and sent home. The laceration was not explored, X-rays were not made. She returned three weeks later apparently in extremis and in status epilepticus with a

brain abscess underlying this compound fracture. The next patient (Photo 1) whose brain abscess is outlined with "Thorotrast" had his scalp laceration sutured in an emergency room and though well explored, no X-rays were made. He was discharged to return with a brain abscess. Subsequent X-rays of the skull clearly showed a linear fracture of the frontal bone into the frontal sinus. Though both patients recovered, complete diagnosis might have prevented these complications. Properly managed scalp lacerations of even considerable magnitude heal with a remarkable latitude of safety and resistance to infection, but in situations such as these, the complications arose from improper diagnosis and occured even in our penicillin era.

Linear Fractures

Simple linear fractures of the skull are of virtually no significance and indicate only that the severity of the injury was sufficient to break the bone. The exception to this is the linear fracture across a meningeal artery groove which may cause epidural hemorrhage, or the compound fracture into the para-nasal sinuses and the ear, with consequent cerebrospinal fluid rhinorrhea and otorrhea. Both the latter require chemotherapy and antibiotic therapy, preferably penicillin and gantrisin, and both virtually always close spontaneously. It is quite rare to be required to make a surgical repair intracranially for persistence of cerebrospinal fluid rhinorrhea and more rare still to have to repair such a leak from the ear.

An interesting and rare complication of fractures into the paranasal sinuses is that of intracranial pneumocephalus or aerocele, secondary to injury through the frontal sinuses. The air may be in the subarachnoid space or ventricular space if associated with a cerebral laceration

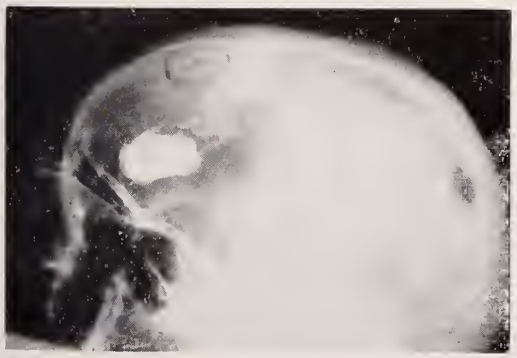


Figure 1



Figure 2

and may gradually burrow into the brain itself, as in the illustrated case. (Photo 2). The lesion requires operation for the closure of the fistulous tract to prevent infection and relieve increased intracranial pressure.

Basilar Fractures

Basilar skull fractures are generally a good deal more serious because of coincident major brain stem torsion-contusion type injury with profound coma. Depressed fractures of the skull, when simple, require surgical elevation if more than 1 cm. depressed, and at times when the depression is of less extent than that because it is well recognized that operation may show them to be worse than the X-ray film indicates. Obviously if the depressed fracture is compounded it needs immediate surgical debridement and closure. This requires a careful debridement of all layers with particularly meticulous cleaning of the devitalized and macerated brain tissue, careful hemostasis and a water tight dural closure, utilizing pericranial or dural graft as required.

Cranioplasty

Tantalum cranioplasty is advisable in all skull defects of any size larger than 3 or 4 cm. in diameter for cosmetic reasons in the frontal areas, and especially for the protection that it affords the brain. Tantalum cranioplasty may be made primarily in even those compound depressed fractures where the period of contamination is brief, but if the wound is especially dirty and macerated and the period of contamination is prolonged, it is better deferred until the wound has healed solidly for several weeks. A secondary tantalum cranioplasty in these circumstances is quite simple and safe and obviates the risk of the wound becoming infected. It is quite surprising to find that some sur-

geons apparently continue to use bone and cartilage in making repairs in the skull under considerable experience of the past war, and since, reveals with some conclusiveness the ease and safety of cranioplasty with tantalum.

It is gratifying to see the gradual passing of the decompression-dehydration regimen of some years past. The decompression in the surgical sense with subtemporal decompression and frequent spinal fluid drainage along with rigid fluid restriction and hypertonic sugar, salt and epsom salts therapy is being replaced with a more rational approach to the injury, based in essence on the idea that cerebral swelling is due as much to anoxia as to injury.

Closed Head Injury

It is a gratifying experience indeed to have a patient who is apparently deteriorating due to intracranial complications, promptly and dramatically improve with nothing more than the administration of fluids and the provision of adequate oxygenation.

We are convinced that in the closed head injuries more lives can be saved and more morbidity reduced than in any other class of head injuries, because of their apparent numerical predominance. An examination of our own statistics of 742 consecutive head injury diagnoses in the past 5 years shows that well over half of these patients carry a diagnosis of cerebral contusion and laceration. The degree of severity obviously varies, but in general the degree of the unconsciousness indicates the severity of the lesion and the gravity of prognosis. Probably the two most important factors in the management of these patients are the maintenance of an adequate airway and constant observation for signs of intracranial hemorrhage requiring surgical treatment.

Cerebral concussion, in general a trivial injury, must always be carefully observed for at least 48 hours. It constantly brings up the question of hospitalization for such neurologic observation. In those patients without residuals after their episode of unconsciousness, and in whom careful and reliable observation can be had at home, we feel they can safely be allowed home to be awakened every two hours during the night following their injury. If such observation is not available at home, it is imperative they be observed in the hospital.

Coma

In the more seriously injured patient with cerebral contusion or unlocalized laceration diagnosed by the presence of blood in the spinal fluid, the management in general resolves itself into the management of coma. By such management the complications of coma can be reduced and prevented in order to allow the patient to recover from the brain injury itself. The mortality from closed cerebral injury in the days prior to chemotherapy was greatly exaggerated by pulmonary complications, and to this day, remains one of the greatest threats to the unconscious patient. It is a constant but most worth while effort to maintain the unconscious patient in the proper position. He should be on his side in a position for good postural drainage of mucus and blood from the pharynx and nose. An aspirating outfit should always be at the bedside of any unconscious patient and is a requirement in the satisfactory management of the oral hygiene. If these conservative means of keeping a perfectly patent dry airway are unsuccessful there should not be the slightest hesitation in making tracheotomy in these patients. One of the most gratifying recent trends in the management of head injury patients, is the increasing use of tracheotomy and the increasing ease with which we can induce our confreres to make the tracheotomy for us, once they have observed the superior results after its use.

There is a distinct drop in the oxygen content of arterial blood after cranial injury. This certainly indicates the need for an adequate airway and oxygen therapy. The seriously injured patient should always receive oxygen, preferably by nasal tube because of its practicability in allowing other procedures.

Hyperthermia is frequently a troublesome symptom of cerebral injury, due to the ease with which the hypothalamic areas are injured. Temperature of 102° or over should be vigorously combatted with the usual measures such as continuous alcohol sponges and the use of aspirin by rectum, and when extreme in degree, even by ice water taps.

Fluid Balance

The patient in coma from head injury should have his fluid balance well maintained and in general should receive from 2000-3000 cc of fluid a day. This is quite a departure from the dehydration of management of cranial injury but if given slowly, it is proper. It is well to alternate

normal saline with 5% dextrose and when the fluid is given intravenously it should most assuredly be given quite slowly. It is indeed possible to induce edema of a contused central nervous system by the rapid dumping of normal saline into the veins. Parenteral fluids may be kept up for a few days in the unconscious patient, but thereafter he should be fed by nasal tube. The soft rubber penrose sheath tubing, introduced by gravity, using a mercury bolus on the end, obviates the disadvantages of the Levin tube in prolonged nasal feeding and lessens the risk of esophageal erosion. Adequate nutrition of the patient in coma for prolonged periods can be maintained only in this manner. Patients in prolonged coma should receive chemotherapy to minimize the hazards of aspiration pneumonia and of urinary infection when an indwelling catheter is required. In the sedation of an uncooperative or restless patient, paraldehyde has received wide acceptance and seems to be a very satisfactory drug because of its wide margin of safety. We believe that it is contraindicated only in those patients who have associated fractures of the long bones, because it is a fat solvent. Physical restraints for the extremely restless are a last resort but may be necessary since too heavy sedation may magnify the problems of neurologic observation, skin care and respiratory management.

Spinal puncture for therapy in cerebral contusion has lost much of its favor. An initial puncture for diagnosis or subsequent punctures for the removal of large amounts of blood in the spinal fluid is useful but frequent taps for the reduction of increased intracranial pressure in severe cerebral contusion appear not only undesirable but at times actually dangerous if there is greatly increased pressure above the tentorium causing tentorial herniation or if the contusion and swelling is largely cerebellar and there is the well known cerebellar pressure cone. However, the irritating effects of decomposed hemoglobin may give rise to delayed fever in which case removal by spinal puncture is desirable. By the application of these principles we feel that much can be accomplished in severe closed head injury.

Intracranial Hemorrhage

One of the most important things is constant observation of the patient for regressive signs indicating intracranial hemorrhage. The various types of intracranial hemorrhage of importance in head injuries are familiar. The subarachnoid hemorrhage which accompanies injury is actually not an entity per se. We feel that it is a symptom of cerebral laceration and have touched on its management. The course of events in the middle meningeal syndrome is generally quite characteristic and many times the diagnosis can be made from history alone. Indeed, on many occasions it is the most reliable indication for surgical intervention, since any of the neurologic findings of the epidural syndrome may be absent. As a rule the patient is rendered unconscious at the time of injury, recovers consciousness for a variable period and then again lapses into coma. The period of consciousness, the so-called free or lucid interval, varies greatly from a matter of minutes to hours and on a rare occasion lasts for several days. Lest we think this interpretation of the interval syndrome a diagnostic feature of intracranial hemorrhage known only to the modern physician, we should remember that Heister is quoted as saying in 1750 of the interval syndrome, that "when the senses are disordered" immediately after an injury to the head "concussion of the brain is much to be feared," but if it occurs at an interval after concussion of the brain, "reason in this case will easily inform us that there is an extravasation of blood in the cavity of the cranium." This extravasation demands immediate surgical relief or death will ensue. If there is doubt about the side of the lesion, bilateral temporal exploratory trephine should be made, the lesion verified and the site of the bleeding meningeal artery controlled.

The findings in the typical case of epidural hemorrhage are an ipsilateral, dilated, fixed pupil and a contralateral hemiplegia with profound coma. We have seen the same syndrome in severe unilateral cerebral contusion, but it is usually well to make the exploration at once unless it is obvious that the patient's condition is steadily improving.

The subdural hematoma following injuries should be separated into the acute, subacute, and chronic because in the acute form they do not constitute as much of a surgical entity. As a rule an acute subdural hematoma exerts little influence and its surgical relief is generally productive of little improvement because it is simply part of a more extensive cerebral injury, laceration, contusion or lobar disruption. The advancing signs of neurologic dysfunction and progressive coma may close-

ly simulate the epidural syndrome and acute massive subdural hematoma is frequently found in a search for the former. The subacute and chronic subdural hematomata carry a much better outlook when diagnosed sufficiently early. The subacute hematoma generally requires operation in the period of one to two weeks following injury as the patient suffers gradual cerebral compression from expanding or liquifying hematoma. The chronic hematoma forms a neomembrane over a period of a few weeks, liquifies and expands, causing progressively more severe headache and coma. Chronic subdural hematoma should always be kept in mind since it may arise from an apparently trivial injury which causes tearing of the veins leading to the longitudinal sinus. In any patient with an apparently mild injury who has continuous and severe headache, the diagnosis of subdural hematoma should be entertained. Any patient in coma, with or without a history of head injury, and in whom the usual reasons for coma are excluded should have a diagnosis of chronic subdural hematoma considered. This is especially true in the aged. These lesions are generally easily relieved by simple trephine drainage. When such tentative diagnosis is made, the trephine should be persisted in until at least four holes are made before the search is abandoned. It is not an uncommon experience to encounter post traumatic hygroma or hematoma in the 4th exploratory trephine hole. When the hematoma is loculated and simple drainage through a burr opening is sufficient to relieve the patient, or the lesion reforms a craniotomy may be required for the removal of the entire neomembrane. This can generally be accomplished through a two inch trephine craniotomy with a considerable lessening of the magnitude of the procedure as compared to the ordinary osteoplastic craniotomy. It should be emphasized that whenever the diagnosis of epidural or subdural hematoma is made, surgical treatment should follow immediately because the end result of too prolonged tentorial herniation of the brain stem is mid-brain hemorrhage (Photo 3).

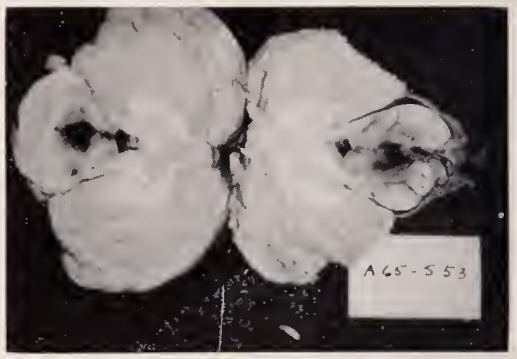


Figure 3

Conclusion

In conclusion, we wish to emphasize the attitude of vigorous non-operative therapy in the closed head injury with constant watchfulness for the neurologic signs that demand surgical intervention.

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The Present Status of the Gout Problem*

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Among the arthritides, gout holds a rather unique and interesting position. Indeed the arthritis would seem to be a more apparent manifestation of a far removed and somewhat obscure disorder. It is striking that many cases go long unrecognized, and it has often been emphasized that in addition to the arthritic findings, more atypical symptomatology may at times be related to the cardiovascular, gastrointestinal, nervous, and other systems. For years gout has been described as a disturbance of the metabolism of uric acid which results in an elevation of the serum uric acid and a tendency toward the precipitation of urate salts as tophi in the cartilages; it is often characterized by attacks of acute arthritis usually with complete subsidence, irregular constitutional symptoms, and ultimately in some cases by gradual disfiguring deposition of urates about the joints.

Incidence

The relatively high familial incidence of gout has long been known. There was a familial incidence of the disease in as high as 75% of cases studied at the Massachusetts General[1] and Buffalo[2] General Hospitals. Hyperuricemia[1] is a frequent finding in the asymptomatic kin of gouty subjects. A single dominant gene,[3] which is not sex-linked, seems to be responsible for the transmission of this state.

It is generally known that the sex incidence favors the male over the female in a ratio of approximately 20:1. Asymptomatic hyperuricemia often begins around puberty in the male but at the climacteric in the female, and the much greater incidence of overt manifestations of gout in the male may be related to the longer period of hyperuricemia.

The onset of gout[1,2] may be as early as the first decade or as late as the ninth but the greatest number of cases occur in the fourth. The earlier the onset of symptoms the greater is the chance of disfiguring arthritic changes developing with resulting serious disability and even death.

Gout[2] affects individuals in all social strata; it affects all races but the incidence among Negroes is relatively low.

Clinical Course

For a clearer understanding of the disease, the natural history of gout may be divided into four phases[4]: (1) asymptomatic "essential" hyperuricemia, (2) acute gouty arthritis, (3) intercritical gout, and (4) chronic tophaceous gout. This division is important because the treatment required in various stages of the disease varies considerably. It must be realized, however, that the grouping is purely arbitrary and, in actual clinical practice, subject to frequent overlapping.

It is becoming increasingly evident that the occurrence of gout is much greater than has previously been suspected, particularly in its mildest form, namely, asymptomatic hyperuricemia. Even though many of these cases are discovered by finding the serum uric acid level elevated (6 mg. % or more) in relatives of gouty individuals, there are undoubtedly others who have only periodic elevations of uric acid which may be easily overlooked. More than that, the generally accepted upper limits of normal for the serum uric acid level is arbitrary and may indeed be lower in certain individuals, thus causing another source of error in case finding. Undoubtedly the great majority of these patients remain in the latent phase of the disease throughout life whereas a few eventually develop overt symptoms.

The first recognizable manifestation of gout is usually an attack of acute arthritis of one or more peripheral joints. Infrequently other findings may precede the attack[2] such as elevation of the blood pressure, albuminuria, passage of urate stones, or the appearance of tophi. Commonly, emotional upsets, trauma, surgical procedures, infections, or certain drugs such as mercurial diuretics, ergotamine, epinephrine, and liver extract are precipitating causes. Also, the probability of occurrence is greater in males of advancing years, prone to dietary and alcoholic overindul-

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gence, and with a family history of the disease.

The onset of the acute attack is sudden, occurring any time[2] during the day or night. The metatarsophalangeal joint is usually affected but other joints of the upper and lower extremities may be involved initially. Only one joint may be involved or several joints in rapid succession. The skin over the afflicted joint is usually tense, shiny and purplish in color, and there is excruciating tenderness and pain.

Systemic manifestations[2] include fever, tachycardia, leucocytosis and elevation of sedimentation rate. The intensity of the symptoms is variable, and the duration of the attack without treatment is unpredictable. Symptoms may subside in 24 hours or persist for several weeks. Complete restitution of the affected joint[4] to normal is characteristic in the earlier stages of the disease.

After the acute attack subsides the patient lapses into a quiescent stage which often lasts for several years, in some cases for the rest of his life. Eventually another acute attack may occur with subsidence and, as time passes, the attacks are apt to become more frequent. Moreover, with repeated involvement of the joints, there is more and more residual stiffness and ultimately the arthritis may advance into the chronic deforming stage.

Thus in a few patients urates are gradually deposited in certain tissues,[4] particularly cartilages, bursae, ligaments and tendons, subcutaneous tissue, and the kidneys. This leads to varying degrees of deformity and disability. Indeed, joints may become ankylosed, or sinuses which drain white chalky material may form. Fortunately, however, only an occasional patient will become a bed-ridden cripple.[2] The precipitated urate crystals also act as foreign bodies and produce inflammatory reactions, atrophy, and degenerative changes from pressure. Punched out areas of bone may be apparent on X-ray examination. Tenderness and deformity of the feet may affect the gait and large subcutaneous nodules of the extremities are also characteristic. For some unknown reason, muscle, liver, spleen, lung, and nervous tissue are resistant[2] to deposition of urate.

The kidneys in chronic gout often show considerable damage. Urate deposits may be extensive in the tubules with concomitant albuminuria, obstruction, and infection. However, there is no characteristic pathological picture. The glomeruli may be eventually hyalinized,[2] the blood vessels may show arteriosclerotic changes, and uremia occurs in a significant percentage of the cases.

Hypertension and arteriosclerosis are frequently seen in gouty patients, but the hypertension[2] tends to follow a benign rather than a malignant course.

Pathogenesis

The cause of gout is not clear. It is known that in man, the anthropoid ape and New World Monkey, uric acid is the end product of purine metabolism by virtue of the lack of uricolytic enzymes such as are found in other mammals, so that the relatively insoluble uric acid must be disposed of as such by renal excretion. Ninety per cent of the urate filtered through the glomeruli[5] is reabsorbed in the kidney tubules allowing only a small fraction for renal excretion. Why a metabolic end product is so carefully retained is not clear, but in lower animals this maneuver is presumably for the purpose of conversion to allantoin in the liver.

Elevation of the serum uric acid is an almost invariable accompaniment of some phase of gout and this suggests a direct relationship with purine metabolism. The purines are ingested chiefly as nucleoproteins which are converted during digestion to nucleotides and nucleosides. Following absorption, hydrolysis and oxidation occur largely in the liver. Hydrolysis results in the formation of the purine bases, adenine and guanine, which are oxidized to xanthine and ultimately to uric acid.

In addition to the exogenous metabolism of nucleoproteins, there are endogenous precursors of uric acid. It has long been known that approximately 300 to 600 mg. of endogenous urates are excreted daily on a purine free diet. The rate of formation of uric acid from endogenous sources[4] depends largely on the turnover rate of nucleic acids derived both from cytoplasmic and nuclear sources. It is of interest that the breakdown of nucleic acid is accelerated in such conditions as polycythemia vera, leukemia, multiple myeloma, and in pernicious anemia following treatment. This may lead to hyperuricemia, and even overt gout may occur. This type of gout[6] is classified as secondary.

Futhermore, as a result of experiments utilizing radioisotopic tracer methods,

there is now evidence that in addition to the above described sources of urate, a substantial portion of urinary uric acid is derived from ordinary protein, carbohydrate, and fat radicals by more direct pathways.

It is understandable that deposition of urate masses about joints and in other tissues can produce inflammatory reactions and displacement of other structures in chronic gout. Urate is most probably deposited in the tissues when the rate of formation exceeds the rate at which it can be excreted. Thannhauser[7] has been one of the strongest proponents of the theory of impaired renal excretion. Unquestionably in the later stages of the disease the presence of renal damage aggravates the condition. On this point there is general agreement. But Thannhauser[7] has suggested that gout may be characterized by a specific renal defect which limits capacity to excrete urate without necessarily affecting other renal activities. Available data on uric acid clearance[8,9,10] do not now substantiate this hypothesis. Actually it is becoming increasingly evident that a significant percentage of these patients show increased urate excretion.

Talbott[11] has been one of the foremost to defend the overproduction theory of uric acid in gout. Whereas some animals are classed as uricotelic, in that the bulk of nitrogen excretion is in the form of uric acid, normal man is considered to be ureotelic because he eliminates nitrogen chiefly as urea[12]. In experimental work utilizing isotopic glycine, [13] there is evidence that increased generation of uric acid from dietary nitrogenous precursors occurs in gout, which, operating over a long period of time can increase the so-called miscible pool of uric acid. It has been suggested[14] that the metabolic defect in gout may be attributed to an unusually large uricotelic component in a predominantly ureotelic species.

One can only speculate on the mechanisms in acute gout, because the manifestations here cannot be so readily explained. Thus uric acid is known to be a relatively inert substance even when injected in large quantities and most probably does not account for the clinical findings of acute gout. On the other hand, precursors of uric acid such as adenosine,[15] are known to have potent vasomotor properties even in small quantities and could conceivably be the responsible agents.

Harkavy[16] has revived interest in the allergic theory, although others [17], [18] have earlier pointed out similarity of acute gout and the allergic reaction. The periodic or paroxysmal nature of the attacks with symptom-free intervals, provocation with small amounts of food and drink in susceptible individuals, and joint involvement with local areas of circulatory disturbance all suggest hypersensitivity. On the other hand, the average age of onset in middle life, the sex predisposition, and monarticular involvement of the great toe do not particularly support this theory. It has been suggested[4] that allergy is a factor in susceptible individuals with deranged purine metabolism.

Finally the precipitation of an attack by nonspecific stresses suggests the concept of the alarm reaction as an explanation particularly since ACTH is effective in alleviating acute attacks. The evidence for a key role of the pituitary and adrenal glands[4] at this time, however, is not convincing.

Treatment

In order to derive the greatest benefit in treating a given case of gout, both the limitations and the objectives of treatment must be realized. In general the management will depend upon the stage of the disease. Many patients with asymptomatic essential hyperuricemia are being disclosed, but since only a few of them will ever develop recognizable gout, it would seem unwise to impose severe dietary restrictions during this phase of the disease. With the first attack of acute gouty arthritis the prospect of progression of the disorder is greatly enhanced and recurrence is the rule. The prognosis is worse if the patient is under thirty-five, has a strong family history of gout, or if a fulminating polyarthritis occurs with the initial seizure. In any case, the acute seizure is treated early with colchicine, ACTH, or phenylbutazone, [3] singly or in combination, in conjunction with early and complete bed rest. Prolonged rest is not required[1] and motion should be resumed as soon as this can be accomplished without pain. Following subsidence of the acute attack it is unnecessary to give prophylactic therapy until it becomes evident that recurrences will be frequent and severe. Then colchicine and dietary measures are most useful. This prophylaxis will of course be continued into the chronic phase. Indeed the dietary restriction should then be more rigid[3] in order to keep the urate load at a minimum. If there is evidence of significant urate

deposit in the chronic stage, a suitable uricosuric agent should be administered concomitantly.

These are the fundamentals of treatment and now the individual measures can be discussed separately.

Colchicine

One of the most important uses of colchicine is to terminate established attacks of acute gouty arthritis. For this purpose it is given in divided dosage of 0.5 to 1.0 mg. every 2 hours until the attack subsides or until diarrhea, nausea or vomiting ensue. Usually substantial relief is obtained after a total dosage of 6 to 8 mg. In perhaps 25% of cases, however, the drug is not entirely satisfactory, [3] and there is ample opportunity for alternate or supplementary therapy. Some acute attacks are refractory to colchicine particularly if treatment has been delayed. Graham and Roberts[19] have reported good results in 24 out of 30 patients treated with intravenous colchicine in doses of 3 mg. Gastrointestinal symptoms were avoided and response was rapid.

A second use of colchicine[3] is to abort impending attacks of acute gout. The observant patient may recognize twinges of pain, tenderness of a joint, or other indisposition. For this purpose 0.5 to 1.0 mg. of colchicine every 2 hours until 3 or 4 mg. have been taken will usually abort an attack without gastrointestinal symptoms. Control of gout is always more satisfactory if treatment is instituted early.

A third important use of colchicine[3] is its regular use in intercritical gout to prevent recurrent attacks. The minimal effective dosage for each patient must be determined by trial and error. Usually 1 or 2 tablets (0.5 to 1.0 mg.) every other night will suffice.

Corticotropin (ACTH)

Corticotropin is effective in most cases of acute gout whose response to colchicine is unsatisfactory. When used for this purpose it should be given in relatively large dosage, [3] that is, 100 to 200 mg. daily for several days and then tapered off to smaller amounts such as 25 to 50 mgm. daily. If the hormone is discontinued abruptly, symptoms often reappear. For this reason, colchicine[20] is useful in conjunction with ACTH. It should be added that corticotropin increases urinary excretion of urates and theoretically would be useful in chronic cases. Side effects, however, preclude its use[3] in the dosage and duration of treatment required. The usefulness of cortisone in gout has been disappointing and definitely inferior to ACTH.

Phenylbutazone (Butazolidine)

Phenylbutazone is a potent analgesic agent apparently non-specific but highly effective [21] in many cases of acute gout. The limiting factor is its great toxicity,[3] including bone marrow depression, retention of salt and water, skin rashes, activation of peptic ulcer and gastric irritation. However, it is often effective in a matter of hours.[21] Thus Kuzell and associates[22] reported complete remission within 48 hours in 25 of 48 attacks of acute gout. Gutman and Yu[3] treated 20 acute attacks, giving 800 mg. daily in 4 divided doses by mouth and remissions were complete or virtually complete within 24 to 48 hours. In this type of short term therapy, some clinicians consider the risks of phenylbutazone to be relatively unimportant but caution in its use is obviously necessary.

Probenecid (Benemid)

Probenecid was first introduced into clinical medicine in 1950 as an adjunct to penicillin and PAS therapy. It was found to suppress tubular secretion of these substances. Gutman, acting on the reports of Wolfson[23] that carinamide was a uricosuric agent, demonstrated that probenecid, a similar drug related to benzoic acid, also had this action. Sirota, Yu, and Gutman[24] reported 15 urinary clearance studies with benemid which indicated that the uricosuric effect is the result of a highly selective inhibition of tubular reabsorption of filtered urate. Investigative studies on 30 patients with chronic gout were made by Talbott[25] in 1950. On 1 to 2 gm. doses a uricosuric effect was noted in 6 hours reaching a maximum in 48 hours. The blood level of uric acid decreased and urinary levels increased. As ingestion of the drug continued, the action on uric acid diminished some but continued to a significant extent even on prolonged intake. Toxicity appeared to be low. Later, 50 cases[26] which were followed 6 to 24 months on benemid (1 to 2 gm. daily) were reported and the favorable earlier reports were confirmed. Pascale and his collaborators[23] treated 20 patients with chronic gout and stressed the use of a large fluid intake during benemid therapy since a larger load of relatively insoluble uric acid was being cleared by the kidneys. Gutman and Yu[3] believe that toxicity to benemid even on protracted therapy is low but since this belief has not

been definitely confirmed, they reserve regular administration of the drug for patients who have already developed tophi, persistent stiffness of joints or other indications of clinically significant deposition of urate in the tissues. In order to prevent new formation of tophi, doses of 0.5 to 1.0 gm. daily are used, whereas for mobilization of established deposits 2.0 to 3.0 gm. daily are employed. In the face of severe renal impairment relatively larger doses are necessary, but with a history of urate calculi or marked uricosuric response, smaller doses are employed with caution, together with a large fluid intake and an alkalinizing salt.

Gutman and Yu[3] have observed 10 patients with tophaceous gout in whom new tophi had appeared with regularity in prior years and in no instance over periods of 6 months to 2 years have new tophi developed or old tophi significantly increased in size once the treatment was adequately instituted and regularly maintained. Indeed the indications are that tophaceous deposits can be mobilized. This is evident from the large quantities of urate recovered in the urine, the general relaxation of joint stiffness, swelling and disability, the drying up of fistulating and discharging tophi, the shrinkage and occasional disappearance of visible tophi, and the diminution of shadows on x-ray caused by urate deposition.

At this time no hepatic or bone marrow toxicity has been observed. Minor skin rashes and allergic reactions have occurred in a few cases.

Cinchophen

Cinchophen has been considered useful in the past, particularly in the treatment of interval gout in patients who failed to respond to other measures. It is still used by some and considered relatively safe by them if care is exercised to be certain that liver function is normal and that an adequate diet high in carbohydrate content is taken concomitantly. It is desirable not to permit patients to ingest alcohol while on cinchophen therapy. The plan of treatment introduced by Graham,[27] popularized by Hench, and later followed by Bartels[28] consists of cinchophen 0.5 gm. 3 times a day for three days a week, the dose being reduced after 4 to 6 weeks to two days a week, finally to one day a week and then omitted entirely. Bartels[28] reported benefit in a group of patients with interval gout who carefully adhered to a low fat, low purine, high carbohydrate diet with the addition of decreasing doses of cinchophen. The excretion of uric acid was facilitated in some instances and the number and severity of further attacks was reduced. With the advent of recent methods of treatment, cinchophen has been abandoned[3] by many groups because of its occasional hepatotoxicity.

Salicylates

Salicylates have been used in acute gout in doses up to 2 to 5 gm. daily. The action is analgesic but not specific, nor is it as effective as colchicine. Acetylsalicylic acid has also been used in chronic gout in larger doses of 5 to 6 gm. once a week to facilitate excretion of uric acid. The action in this capacity is inferior to benemid, and it must not be used concomitantly with the latter for it interferes with the uricosuric action of benemid.

Diet

Taking into consideration the facts presented earlier, it is obvious that purine formation cannot be controlled by manipulation of the diet alone; nevertheless, the composition of the diet is a significant consideration in management.

There are two main objectives: avoidance of the precipitation of acute attacks, and a reduction to a minimum of the general trend of deposition of urate in the tissues. Talbott[2] stresses the importance of liberal ingestion of liquids since the relatively insoluble uric acid is near the saturation level in the body fluids and glomerular filtrate. The fluid intake for the most part should be in the form of water in order not to raise the caloric intake, since excess of weight is also to be avoided.

Purine foodstuffs markedly increase the purine load as measured by increased urinary excretion. Such foods include herring, anchovies, meat extracts, calf brains, spleen, liver and kidney. Other nitrogen sources contribute to the urate load to a lesser degree. Diets high in fat, in addition to causing gain in weight, depress renal excretion of urates. Carbohydrates[3] do not seem to appreciably affect urinary urate excretion.

Dietary regulation is difficult and each case must be individualized according to his requirements and tolerances; moreover, patients vary in the susceptibility of their gout to diet. Overindulgence of food and alcohol has long been known to be a precipitating cause of acute gouty arthritis. However, some patients are thus harmed

more than others. Nevertheless the safest practice is more or less complete abstinence from alcoholic beverages and temperate dietary habits at all times. Any article of food known to be an inciting factor should be avoided. Beyond this no rules are established for the earlier stages of gout. Gutman and Yu[3] begin with a very restricted diet in conjunction with colchicine prophylaxis and gradually liberalize it depending on individual tolerance.

In the later stages of gout, or when the principal objective of dietary regulation is to minimize urate deposit, a diet low in purines, limited in protein to 60 to 80 grams, and low in fat is utilized. Here again the diet may be gradually liberalized especially if effective uricosuric agents are available.

Surgery

Talbott[2] in particular stresses the surgical treatment of chronic deforming gouty arthritis. This method will apparently be less often necessary since the advent of efficient uricosuric agents. However, large unsightly painful tophi about joints, particularly those that interfere with the wearing of gloves or shoes, or those especially susceptible to trauma may require surgical removal. It is important to use colchicine (1.5 mg. daily) for at least 3 days prior to surgery in order to minimize the possibility of precipitating acute arthritis.

Summary and Conclusions

According to available evidence, gout is a hereditary inborn error of purine metabolism characterized by attacks of acute arthritis, irregular constitutional symptoms, and hyperuricemia with a tendency toward deposition of urates about the joints.

The stages of gout include (1) asymptomatic essential hyperuricemia (2) acute gouty arthritis (3) intercritical gout, and (4) chronic tophaceous gout, but there is frequent overlapping of these stages.

Uric acid is derived from exogenous purine sources, endogenous cellular breakdown, and by direct pathways from simple radicals. Urate is most probably deposited in the tissues in chronic gout when the rate of formation exceeds the rate of excretion of uric acid.

The management of gout involves the prevention and suppression of acute attacks and the prevention and mobilization of tophi. Colchicine, corticotropin and phenylbutazone are useful in acute gouty arthritis. Colchicine is the most useful but is not always entirely satisfactory, thus allowing opportunity for alternate or supplementary therapy. Probenecid (benemid) is an effective uricosuric agent in chronic tophaceous gout, probably suitable for long term therapy, apparently essentially non-toxic, and capable of mobilizing tophi. The precise role of this agent has not been definitely established at this time, however. Although urate formation cannot be controlled with diet alone, a diet low in purines, limited in protein to 60 to 80 gms., and low in fat is considered to be advantageous in the management of chronic or recurrent gout.

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Psychiatric Aspects of Organic Brain Disease

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Throughout the era of modern medicine a dualistic concept of disease has existed, that is, disease is either "organic" or "functional." The dichotomy of mind and body is still prevalent, even among psychiatrists. This concept is confusing as well as misleading. All disease must be organic and functional because without a disturbance in function there can be no symptoms and without physiological involvement there can be no disturbance in function. In short, function is the result of an organ in action. Disordered function not traced to a demonstrable cause today may be so traced tomorrow. All cerebral activity, for instance, whether conscious or unconscious, must have its physiological basis, the exact mechanism of which is unknown.

Organic Brain Disease

The brain is the organ of the mind and lesions of the brain may affect personality directly or secondarily by complex psychological reactions. In the American Psychiatric Association classification of psychiatric illness about 60% of mental disorders are now accepted as being of organic origin—psychoses due to infection, trauma, tumors, intoxication, disturbances in circulation, metabolic and endocrine disorders. Let us consider one of the earliest studied types of organic brain disease, meningo-encephalitic syphilis or paresis. This was assumed to be due to psychic causes as late as the turn of the last century. In 1906 the Wasserman reaction was introduced and in 1913 Noguchi and Moore demonstrated the spirochete treponema pallidum. Despite the presence of similar pathological lesions, psychoses associated with paresis may assume any form and variety including simple deterioration, hypochondriasis, manic, paranoid, depressive and schizophrenic states. Yet individuals have died with a fully developed paretic brain without having shown any psychiatric or neurologic disturbance. Physical treatment alone such as penicillin or malaria may cure the psychosis in many cases. Paretics with severe depressive or manic states may obtain a remission with electro-shock therapy. Quite frequently after treatment, behavior may become normal while the spinal fluid serology persistently remains abnormal. In addition, there is the so called asymptomatic neurosyphilis with its paretic spinal fluid and absence of clinical symptoms. And finally, Hollos and Ferenczi (1) have stated that the psychotic manifestations of paresis as well as the entire course of the disease proves to be accessible to psychoanalytic explanation. In short, what has previously been considered a clear cut organic psychosis assumes many ramifications with the undeniable importance of psychological influences.

This disparity becomes understandable if we think of the disease process as lowering physiological resistance and leading to a weakening of established ways of dealing with anxiety. A regression to infantile emotional levels may take place and secondary reactions set in which attempt to ward off the threatening anxiety. This type of reaction will depend upon the patient's previous personality structure and the defense mechanisms to ward off anxiety created by the organic disease may be more crippling than the disease itself.

Ways of Reacting

A person may react to physical illness in general in various ways:

1. A normal reaction may consist of some anxiety and depression which soon decreases commensurate with the severity of the illness.

2. An avoidance reaction may take place which is a denial of illness with overactivity, false gaiety and non obedience to medical instructions.

3. There may be a reactive depression which is a prolonged depression but self limited in nature.

4. Psychological invalidism may occur. The patient's fears or symptoms make him an invalid although physically recovered.

In a recently published book, entitled, "When Doctors are Patients," (2) several physicians describe their reactions to their own serious illnesses; the outstanding feature was the importance of the emotional overlay. Patients were often more concerned with something they feared rather

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than their real illness. Organic and neurotic symptoms were subjectively experienced in the same way and there was little doubt as to the importance of the modification of the personality by the disease.

Involvement of the brain gives rise to further problems since the brain has always been regarded as a sacred organ and impairment in its function engenders fear of insanity and a fear of loss of control over ones actions. This fosters a psychogenic overlay, either of anxiety, hysteria or depression and makes it imperative that the physician be familiar with the clinical features of organic brain disease as well as being aware of the various types of psychological reactions to illness. Several cases are cited to illustrate these points:

An Illustrative Case

A 36 year old married woman was first seen on September 19, 1949. A week previously she had suddenly become dizzy, couldn't focus her eyes, had double vision and a staggering gait. The following day she felt fatigued, sleepy, depressed, and had a headache. She noticed difficulty in walking and manipulating her left hand. She felt that it was a great effort to talk or do anything. When not depressed she felt silly, and couldn't think straight. Neurological examination showed haziness of the left optic disc. There was a left facial weakness, thickened speech and slight adiadokokinesis of the left hand. Reflexes, coordination and sensation were intact. Skull x-rays were negative. Spinal tap was also negative except for an elevated colloidal gold reaction. Visual fields were normal. An electro-encephalogram obtained two months later was statistically abnormal but not diagnostic of any definite clinical entity. Psychological tests suggested a neurotic picture with anxiety, hysteria and depressive features. The clinical impression was that of Multiple Sclerosis. Because of the severe depression with suicidal impulses the patient was seen in psychotherapy twice a week for a long period of time and then intermittently for the next four years. The neurological findings cleared up within a few weeks without changing the psychiatric picture. Her illness had occurred shortly after the birth of her third child, which was an unwanted pregnancy. She had feelings of inadequacy due to her illness and a fear of becoming an invalid—a burden to her family. They had always depended upon her and she feared a loss of their love. Her mother had died when the patient was 14 and her father died before her birth. She felt that she had been let down in many ways and was afraid to depend upon others.

Her only brother died about the age of 12 of a pituitary tumor. Her mother was hit by a car and killed but at the time was depressed and sick. The patient has always wondered whether she committed suicide. She went to live with an aunt but resented her domination. After six months she left and obtained employment as a maid. Later she went through nursing school. She discussed her insecurities and hardships as a child and a tremendous amount of conflictual material was released. She vented childhood hostilities and abreacted as if she were reliving her experiences. She had intense guilt over her last pregnancy and ambivalent feelings towards the baby. She had always taken pride in her self sufficiency but her illness had reduced her to a dependent person anxious for attention and someone to lean upon. During this period she had occasional episodes of vertigo, facial pain and memory disturbance and would phone the therapist seeking reassurance which was freely given. At times when anxiety became acute she was given a special appointment with the opportunity to ventilate her feelings. She indulged in day dreaming to compensate for her feelings of inadequacy and inferiority over her physical appearance, particularly her obesity. The diagnosis was never mentioned but her illness was interpreted as being due to a transient spasm of the blood vessels precipitated by fatigue, worry, and excessive smoking.

The patient gradually improved and was able to function on a reality level rather than indulging in fantasy. She was supported through the stress of two more operations, a hysterectomy and hemorrhoidectomy. In May, 1953 she phoned for an appointment but could not be seen for two or three days. On her way to the office she developed a sudden flaccid right sided hemiplegia with involvement of the brain stem. This cleared up within 24 to 48 hours. Intravenous histamine was administered but the part it played in her improvement is impossible to evaluate. Of interest is the patient's comment that if she had been able to get to the office to discuss what was on her mind she would not have had her "stroke." She had been under a period of severe emotional stress which was more than she could tolerate. Interviews were again resumed with subsequent improvement. This case raises several interesting questions.

Multiple Sclerosis is a symptom complex of unknown etiology. Symptoms are often considered hysterical in origin until the neurological findings establish the diagnosis. Are the so called hysterical symptoms due to cerebral changes which can not be measured by our present methods or are they indications of an unstable, immature personality which is so often present in Multiple Sclerosis. On the other hand is it not possible that in certain individuals anxiety may produce vascular phenomena in the brain resulting in the group of symptoms recognized as Multiple Sclerosis. According to Putnam (3) the characteristic demyelination depends primarily on the thrombosis of small veins of the brain which may be brought about in many ways. It has been recognized that unusual strains such as pregnancy and infection may accentuate symptoms of Multiple Sclerosis. Emotional factors may act the same way. Langworthy (4), in describing a series of cases of Multiple Sclerosis, felt there was a definite relationship between personality problems and the onset and progress of the disease. In view of the lack of any specific treatment, he stated that psychotherapy was the most effective approach to the problem of treatment as it may influence recent symptoms and prevent progression.

In the patient under discussion there seemed to be a definite relationship between her emotional turmoil and the production of neurological symptoms. The onset of organic cerebral symptoms released a severe underlying neurosis with much repressed conflict which could be treated by the same technique as any other neurotic disorder.

Psychosis With Brain Tumor

A thirty-eight year old miner was admitted to Wayside Hospital March 5, 1953. He had been discharged from the Good Samaritan Hospital in February of the same year after the operative removal of a malignant brain tumor followed by a course of x-ray radiation. On his return home he had spells of irritability and threatened to kill the family. Shortly before his present admission he began growling and snorting like a mad dog, and threatened his wife with a knife. She stated that he had always loved his family and had been a good husband but since the operation had turned against them. Neurological examination showed a slight right facial weakness and increased tendon reflexes on the left side with a positive Babinski. The patient was reared in a mountain community but had the advantage of completing high school and two years of college. He entered the mines for a couple of years and then moved to Pennsylvania where he worked until enlisting in service. He served for four years and saw action on Guadalcanal. His health remained excellent except for bouts of malaria. After discharge he worked in a rubber plant in Akron, Ohio where he met his future wife. She had previously been married and divorced and had three children, 7, 9, and 10 years old, who were being raised in an orphanage. The patient had a son born out of wedlock and because of strong guilt feelings he finally married his wife when the baby was seven months old. Three children were born to this union, one dying at birth. The oldest boy developed polio with residual weakness of the extremities. The younger girl required much medical attention for minor complaints. Last summer his wife's children, now age 13, 15 and 16 were taken out of the orphanage and returned to live with them in Kentucky where the patient had resumed his work in the mines. Shortly thereafter he began to develop severe headaches and was finally hospitalized for a brain tumor. Following admission to Wayside Hospital he did not recall too well his psychotic episode and tended to minimize it. He recognized that he had been quite irritable, upset by noises, had the feeling that things weren't right and was worried and upset by his disability and fears about the future. Initially, his speech was circumstantial with definite evidence of memory impairment, concretistic thinking, and mild paranoid thought content directed toward his wife. He was always excessively polite and deliberate in speech. He gradually related well and talked more freely, seeming to gain relief by doing this. He expressed guilt about his son's birth out of wedlock and for his subsequent development of polio which he regarded as punishment for past sins. He resented the responsibility of raising his wife's three children as they did not fit into the mountain culture and were a constant source of irritation. The oldest girl was difficult to manage. The fifteen year old boy still wet the bed regularly. He verbalized religious conversion symptoms, expressing the desire to be saved and voicing regret over his sins. One of the chief sources of anxiety was his feeling of insecurity for the future as he had always been proud of his ability as a

wage earner, who could provide well for his family. He had the obsessive fear that the family would not have enough to eat.

Psychological tests revealed a level of general intelligence within normal range. Organic pathology was definite with indications of a progression towards restitution of function. The premorbid personality was that of a rigid, compulsive individual who was able to keep his underlying hostility under control. The organic pathology had operated to break the pre-existing controls making him unable to cope with his hostile and aggressive impulses which erupted into violent behavior.

The patient gradually improved and showed no evidence of psychosis. He enjoyed discussing his problems and was able to reorient his attitudes in many ways to lessen his anxiety of the future. He was helped to formulate plans with his wife's aid to return her three children to the orphanage and was aided in obtaining financial assistance. He returned home where he died a few months later from a spread of his malignancy. This case illustrates an individual who had always made an excellent adjustment. Under the stress of a brain lesion he was unable to cope with pre-existing tensions and reality problems and suffered a temporary psychosis. The content of his delusional thinking was directly related to his personality problems.

Depressive Overlay

A thirty-six year old married woman was originally seen in psychiatric consultation at St. Joseph Hospital on August 27, 1953 at which time she showed a psychotic reaction characterized by confusion, memory loss, hallucinations and depression. She complained of urinary discomfort and voided specimens were a dusky brown color characteristic of porphyrinuria, the diagnosis of which was verified by quantitative porphyrin determinations as well as a change in the color of the voided specimen when exposed to sunlight. The patient related that for several years she had had episodes of passing this type of urine. She had been hospitalized in a local hospital practically all summer because of periods of confusion, incontinence, abdominal pain and loss of weight. Neurological examination was essentially negative except for a tic like movement of the left arm which she constantly flexed and extended. At the time of discharge she was in good contact without any evidence of psychosis. She showed memory impairment for recent events, characteristic of an organic cerebral involvement. Depressive symptoms were mild and seemed to have cleared up coincidently with the disappearance of porphyrin from the urine.

She was readmitted to the Good Samaritan Hospital January 4, 1953. At this time she was again psychotic with disorientation, auditory hallucinations, vivid terrifying delusions and severe depression. At night she would be delirious and expressed the delusion that she had been chopping up her children for fish bait. Memory again was severely impaired. The hallucinations and delusions gradually disappeared but she remained depressed, as manifested by extreme inertia, insomnia and total loss of appetite to the extent that she ate practically nothing for a week. She expressed the feeling that she was just a burden to her family and would be better off dead. It was noted that her condition again became worse at home concurrently with the passage of red urine due to her porphyria.

The patient had been married three times and her present husband was thirty years her senior and in poor health. She had been married to him for six years, having first worked as his housekeeper and marrying him over the protests of his grown children, who never accepted her. She had acquired syphilis in 1941 from her second husband and had had intensive treatment for this. Both her parents had died during her early childhood and she had been shifted from one place to another, marrying for the first time at the age of thirteen. Her mother had committed suicide by shooting, and her brother, of whom she was quite fond, had also suicided twenty years ago. She had one other brother who was an alcoholic. She had an 8th grade education and had taken a correspondence course in nursing. She had worked as a mid-wife for fifteen years and had the reputation of being a sensible, competent woman.

The depression continued despite the absence of porphyrin in the urine. Porphyria is a metabolic disorder, characterized by periodic abdominal complaints, neurological and psychiatric symptoms. It is a recurrent illness for which there is no specific treatment. It was felt that the patient had always been a depressive type of character and that her illness had weakened her defenses to produce a profound mental disturbance. Her current problems and past experiences were sufficient to cause a depressive reaction. She was given a series of six electro-shock treatments,

following which she became cheerful and active and was again in good contact with her environment. She was seen for a follow up interview five months later, at which time she was maintaining her improvement although mild depressive symptoms were still present. Her husband had conveniently died, affording her more financial security. She had had one more episode of smoky urine without psychotic symptoms and was cared for in her local hospital. She expressed the feeling of being unloved by her children and was overprotective toward them as well as emotionally dependent upon them. This patient represented a severe psychogenic overlay of depressive nature in a metabolic disturbance usually associated with mental symptoms. Definite improvement took place with electro-shock treatments.

Conclusion

A dualistic concept of disease as being organic or functional is untenable. The person as well as his disease must be treated. The symptomatology of organic brain disease should be considered due to a combination of specific organic brain defect, and a psychological reaction to the defect producing a realignment of personality forces and compulsory mechanisms designed to diminish anxiety.

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Employment and Heart Disease

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The widespread misconception that heart disease is necessarily incompatible with productive work must be eradicated. The Kentucky Heart Association is attempting to educate all concerned that individuals with heart disease can and should work. With a careful history and a little investigation as to the physical effort involved in the contemplated job, physicians can return many cardiacs to gainful employment and they can help educate the public to the fact that within reasonable limits and under medical supervision, the majority of persons can keep safely on the job.

Job Placement

There is still concern on the part of an employer who fears the possible risks involved in hiring a person with heart disease. The American Heart Association has been disseminating information to the effect that the employer can safely hire such workers. Their publications (1) offer this reassurance: if the employee is known to have an abnormal heart condition and has been placed in a job for which he is physically qualified, the employer as well as the worker runs no special risk. In fact, the employer runs a greater risk in hiring a worker with an unknown or unsuspected heart ailment for a job that might endanger other employees as well as himself.

Guided by a physician's recommendation, it is not difficult to determine which job or jobs the cardiac can do without exceeding his limitations. When the worker is placed in accordance with these limitations, he ceases, for all practical purposes, to be handicapped.

The limitations for the proper placement of most cardiacs can be simply stated. They involve only prohibition of heavy labor, such as climbing, excessive walking or standing, and heavy lifting.

Employment After Myocardial Infarction

We have been particularly concerned with the employment problems after re-

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covery from a myocardial infarction. The many reports of long term survivals after an acute myocardial infarction have encouraged most physicians to assume an optimistic attitude to the ultimate prognosis of this disease. More patients live longer than is generally appreciated. We (2) recently studied 484 patients who had lived more than two months after their first myocardial infarction. Of 151 such individuals who had a five-year study, 61 per cent lived five or more years, whereas 39 per cent died within five years. Some patients are still living after twenty years of observation.

However, many physicians still consider the person who has survived a myocardial infarction as being permanently and totally disabled. The following statements appear in the literature: "With regard to business activities, it is often wise to raise the question of retirement. Those with many interests, who can afford it, should retire." "We might as well consider that such patients are permanently disabled and count it hardly worthwhile to attempt to return them to active life." (3, 4).

We have attempted to counterbalance this pessimistic attitude. Of the 484 patients mentioned above, 76 per cent made an economic recovery. Only 12 patients elected to retire in the absence of symptoms. There were varied reasons for this decision: a pension, disability insurance, inability to change their work status, economic ability to retire and so on. A very high percentage of those in the younger age groups returned to work. Many of the older patients with symptoms of angina or congestive heart failure elected to retire.

Duration of Employability

If a person with heart disease does return to work, the physician is often asked how long will he be able to be productive. We have answered this question as regards the individual who has had a myocardial infarction. A study was made of the ultimate prognosis of 344 men who, after their first myocardial infarction, became employable to such a degree as to constitute economic rehabilitation (5). They were in various occupations representing all phases of economic life. The majority were in some aspect of business, either in an executive or sales capacity, and the laborers (23 per cent of the total) were both skilled and unskilled. The majority (78.5 per cent) were below the age of sixty. This was to be expected since older men are more liable to be unable to return to work or elect to retire. But it is of interest that ten men in their eighth decade returned to gainful employment.

Of the 344 patients, economic activity ceased, either through death or retirement, for 113 or 32.8 per cent. This occurred within five years for nearly three-fourths of this group. The disability rate was especially high for the first three years. However, two patients were able to work sixteen and nineteen years respectively before they died or retired. The work status naturally altered over the years but the final illness of the majority of those who died was very short. This is because they died suddenly or shortly after another myocardial infarction. The average duration of economic activity of those who died or retired was four and a half years. A five-year work study was valuable. Of 117 patients observed for this period of time, 63 per cent worked five or more years, whereas 37 per cent ceased work, either through death or retirement, within five years.

Death from or retirement by cardiovascular disease was not influenced by the return to work. Moreover, none of the patients who had an aggravation of their preexistent heart disease ever claimed that it was due to their work and hence was compensable through Workmen's Compensation Insurance.

Since sudden or relatively sudden death or fainting attacks can occur in cardiacs, particularly those who have had a myocardial infarction, men engaged in work hazardous to their fellow employees or to the public, such as crane operators, bus drivers or railroad engineers, should be advised to change their employment.

The complaints of the patient are the best guide to economic recovery after an episode of congestive heart failure or a myocardial infarction. The patient does not have to be completely free of such symptoms as mild shortness of breath or an occasional attack of angina pectoris. Elaborate hemodynamic studies to determine the integrity of the myocardium or the coronary circulation are not necessary. The electrocardiogram is a helpful guide in attempting to determine whether a myocardial infarction has healed, but in most instances it never returns to normal. This should not exclude gainful employment.

Legal Aspects

Judicial interpretation of the Workmen's Compensation Act can be a deterrent to-

wards the employment of individuals who have heart disease. "Acceleration of previously existing heart disease to a mortal end sooner than otherwise it would have come is an injury within the meaning of the Workmen's Compensation Act" is an accepted legal opinion. This reasoning has always been applied to criminal and civil cases. A criminal cannot escape guilt if it happens that his victim is physically weak and for that reason cannot withstand the blow and dies, even though the same blow inflicted upon a normal person would not have resulted seriously. The Kentucky Court of Appeals has decided, however, that compensation must be apportioned; that is, the Commissioner is to award an amount commensurate with the part played by the accident. If the accident was one-half responsible and the heart disease equally the cause, then fifty per cent of total compensation should be paid.

There are certain occupational hazards which must be avoided by an individual with known heart disease, particularly an old myocardial infarction. They are: (1) intense and sudden physical exertion and emotional excitement; (2) working in an atmosphere of relatively low oxygen or high carbon monoxide content; (3) working in extreme degrees of heat and cold; (4) electric shock; (5) shock from accidents or surgery resulting from accidents; (6) penetrating and nonpenetrating injuries to the heart.

Aids and Deterrents to Rehabilitation

The Division of Vocational Rehabilitation and the Department of Economic Security of the State of Kentucky, together with various labor unions, can be of considerable help to heart patients. They have well integrated program of rehabilitation and vocational training of people who cannot return to their former jobs.

The heart surgery program for indigents sponsored by the Kentucky Heart Association will help rehabilitate some individuals with mitral stenosis and selected types of congenital heart disease.

The Heart Association has given much publicity to the problem of housewives with heart disease. Women, in general, despite their disease, are expected and should be encouraged to continue with many of their household duties and responsibilities. A "Heart of the Home" program has been devised to show such housewives how to simplify and lighten their work.

Fear is the biggest obstacle the heart patient has to overcome. He is often afraid of the amount or kind of work he can do. By guidance and encouragement, the physician can help with rehabilitation. People with heart disease are better off working than worrying. When the capabilities and limitations are determined, the worker should be told that work will not cause an aggravation of the old heart trouble. He should make every effort to be rehabilitated so as to become a useful citizen, even though he may have to learn a different kind of work at a lower salary.

The young cardiac should give especial attention to his life work. It is best if he learns at an early age a trade which involves a minimum of physical effort.

Organized labor can be very helpful to its members who develop heart disease. When a cardiac is transferred to a lighter job, other employees at times resent it. The union should educate its members to help the handicapped and cooperate with management in the rehabilitation of their sick fellow workers.

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A New Era in Vascular Surgery

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The first successful surgical attack upon a congenital anomaly of the heart or great vessels was in 1938 when Gross ligated a patent ductus arteriosus[3]. This introduced a new era in Vascular Surgery which has rapidly developed into an exciting and constantly expanding field. A few of the lesions, both congenital and acquired, which are now being treated successfully will be discussed.

Patent Ductus Arteriosus

Since the original successful ligation of a patent ductus, Gross has reported over 600 patients operated upon for this condition. 568 patients have had complete division of the ductus (Figure I) with a mortality rate of less than 0.5% in the uncomplicated cases[4]. In the majority of cases the diagnosis is made readily by the characteristic continuous murmur heard in the second or third intercostal space to the left of the sternum. Rarely does one have to resort to cardiac catheterization to make the diagnosis. The prognosis in untreated cases as reported by Keys and Shapiro is not a happy one[26]. Patients alive at 17 years of age with a patent ductus have a life expectancy of only half that of the general population. The hazards to which these patients are subject are: retarded physical development, cardiac failure, bacterial endo-carditis, or aneurysmal dilatation or rupture of the ductus. For these reasons operation is advised for all patients with a patent ductus, the only exception being those few patients who are cyanotic. Cyanosis indicates either a complicated cardiovascular malformation for which the ductus is acting as a compensating mechanism or the patient is in terminal heart failure. Although operation may be performed anytime from infancy to adulthood, the optimum age for operation is between six and twelve years.

Coarctation of the Aorta

Coarctation can occur in any segment of the aorta, but nearly always occurs in the first portion of the descending aorta just at the ligamentum arteriosum. The diagnosis is usually made quite easily clinically. There is a marked disparity between the blood pressure in the arms and legs; a hypertension in the arms is the usual but not essential finding. The femoral pulses, when palpable, are slightly later in time than the radial pulse. In older individuals the collateral arterial channels are well established, can readily be seen and felt and on X-ray the characteristic notching is seen. Laboratory studies are generally unnecessary. However one of the few uses for the ballistocardiogram is that there is a characteristic change in coarctation of the aorta. More exact information about the location of the lesion can occasionally be obtained through angio cardiography.

Reifenstein et al[5] made an extensive review of accumulated autopsy material in Greater Boston over several decades and found that of all patients with a patent ductus: 25% lived to an average age of 47 years and were relatively asymptomatic.

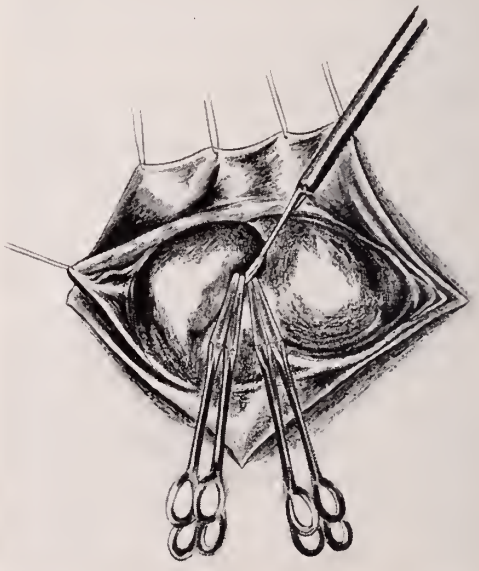


Figure 1. After Gross, R. E., J. Thoracic Surgery 16, 314, 1947. Four hemostats are placed on the ductus between the aorta and the right pulmonary artery. The ductus is divided between the two middle clamps. The ends of the ductus are then closed with an over-and-over stitch.

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25% died of bacterial endocarditis at an average age of 28 years. 25% had sudden death from rupture of the aorta at an average age of 27 years, this hazard being particularly great during pregnancy[6]. 25% died from complications of hypertension. In 1944, Blalock & Park[7], reported a treatment of experimental coarctation in dogs. This consisted of bringing down the left subclavian artery and anastomosing it to the aorta distal to the atresia. In 1945, working independently Crafoord[8] and Gross[9], both reported a superior method which was used successfully. This method consisted of excision of the stenotic area and end to end anastomosis. This method has proved most successful in the short lesions, however, it is not suitable in the longer lesions. The Blalock method had to be used for these lesions until 1948, when Gross et al,[27], developed a method of using preserved homografts. (Figure II). Since this time, many grafts have been used and some have now been followed for as long as five years without evidence of aneurysm, rupture, or signs suggesting embolism[4]. The history of the development of vascular grafts and the various methods of preservation including sterilization by 3 million volt electron-beam cathode-ray machine, is another subject in itself.

The mortality rate as reported by Gross[4] for the last 100 cases was 2%. The postoperative blood pressure showed 88% cure of hypertension, 10% a satisfactory relief of hypertension and 2% had no relief of hypertension. The morbidity rate was extremely low. From a series of 270 cases there were two who developed spinal cord damage, both of whom were over thirty years of age. One patient had delayed bleeding which ended fatally one year after operation.

In view of these excellent results operation is recommended in all cases except those who have severe rheumatic mitral disease or severe aortic insufficiency. The optimum age for operation is between 10 and 18 years, when the aorta has attained a reasonable size, yet retains its elasticity.

Vascular Rings

Vascular rings result from a variety of anomalies of the aortic arch any of which encircle the trachea and oesophagus. Gross and Neuhauser[10], have listed these as follows: 1) Double aortic arch. A) Large posterior arch and small anterior arch. B) Large anterior arch with small posterior arch. C) Right descending aorta with small left descending aorta. 2) Right aortic arch with left ligamentum arteriosum. 3) Anomalous left carotid artery (arising from aortic arch further to patient's right than normal. 4) Anomalous innominate artery (arising from arch further left than normal. 5) Aberrant subclavian artery. A) Right subclavian artery has origin from left side of aortic arch and runs behind oesophagus. B) Right aortic arch with left subclavian artery running behind oesophagus.

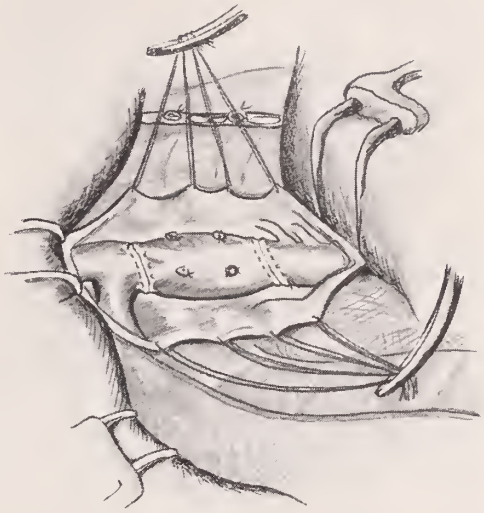


Figure 2. After Gross, R. E., Annals of Surgery, October 1951. An elongated segment of constriction has been removed and replaced by a preserved homograft of adequate diameter and length.

The most striking symptoms from this condition result from the constriction to the trachea. The child has obvious labored respirations which are aggravated by swallowing. The head is held in hyperextension and forceful flexion may completely cut off the air passage. Intercurrent pulmonary infections are common and very serious. The diagnosis can easily be made by X-rays with barium in the oesophagus and lipiodol in the trachea. In 1933 Sprague and associates[11] suggested the possibility of surgical correction of this condition, however it was not until 1945 that Gross[12] performed this operation for the first time. Since that time, he has reported 57 operations for this condition with five deaths. Those surviving operation all had excellent results[4]. Bohnson & Blalock[13] have reported a patient with a double aortic arch and a tetralogy of Fallot; the anterior arch was divided and the proximal end ligated, the distal end

was anastomosed to the left pulmonary artery thus relieving both conditions. Although it is possible to have a vascular ring without symptoms, it is advisable to correct those giving symptoms as early as possible before the trachea is permanently deformed.

The Tetralogy of Fallot

For over half a century this condition has been known to the medical profession as pulmonary stenosis or atresia, combined with dextroposition of the aorta, high ventricular septal defect and right ventricular hypertrophy. Taussig[14] emphasized the abnormal physiology and showed that the cyanosis was due to the mixture of oxygenated and unoxygenated blood through the over riding aorta and to poor blood flow to the lungs because of the obstruction to the pulmonary outflow. Understanding of the dynamics of the deformity led her to believe that these patients could be helped by a surgical procedure to improve the pulmonary circulation.

It was this concept that led Blalock[14] to devise his ingenious operation which is responsible for this previously obscure disease now being widely known both to the layman and to the medical profession as the blue baby. Since Blalock's operation which consisted of anastomosing the subclavian artery to the pulmonary artery, Potts, et al[15], have modified this technique by anastomosing the aorta to the pulmonary artery. Brock[16] has taken a more direct approach and attacks the pulmonary obstruction directly.

The diagnosis of this condition can occasionally be made by physical examination and the ordinary laboratory methods including X-ray and E. K. G. without resorting to cardiac catheterization, although this is frequently necessary. The prognosis for untreated patients is grave and few live to middle adult life. The results of operation are for the most part unpredictable in each individual case, however, a high percentage have excellent results; others have less marked improvement and a small minority are not helped at all or are even made worse. The optimum age for operation is roughly between 4 and 14 years.

Interauricular Septal Defect

This results in an arteriovenous shunt with recirculation of arterial blood through the pulmonary circulation. This is the most common congenital lesion of the heart occurring as the sole lesion. Although small lesions may be well tolerated into late adult life, larger lesions are poorly tolerated and frequently end in right sided heart failure during childhood or early adult life. The diagnosis of this condition can be made frequently without cardiac catheterization, but this method is quite valuable in determining the severity of the left to right shunt. The chief problem encountered in repairing this defect is exposure of the septum for a sufficient length of time to make the repair. Attempts have been made to close these defects by invaginating part of an auricle into the defect[17,18,19]. This method has the advantage of simplicity but the disadvantage of not closing the defect accurately. Denis et al[20] have attempted closing these defects by using a mechanical heart. By means of refrigeration Baily[19] has prolonged the length of time that he can occlude the venous inflow and thus directly expose the septum. Gross and associates[21], have developed a rubber well which is attached directly to



Figure 3. After Gross, R. E., S. G. & O., January 1953. With the atrial well in place, the septal defect can be repaired thoroughly and without haste.

the auricle through which one is able to operate upon the septum with precision and without haste. (Figure III) The procedure offers great hope for a large group of patients because when the defect is effectively closed, the patient is completely rehabilitated.

Mitral Stenosis

This is the most commonly occurring acquired lesion of the heart which is amenable to surgery. In 1923, Cutler[1] attempted the first valvulotomy for mitral stenosis. Two years later the first successful surgical treatment of mitral stenosis was obtained by Souttar[2]. However, because of the high mortality and the high incidence of mitral regurgitation, the procedure was abandoned. In 1946, Bland and Sweet[22] were impressed by the fact that patients with Lutenbacher's syndrome were not subject to pulmonary edema as were the patients with mitral stenosis but without an atrial defect. They were also impressed by the marked dilatation of the bronchial veins in mitral stenosis. Thus a shunt from the pulmonary to the systemic circulation seemed beneficial. Feeling that it would be technically easier and safer to form an extracardiac shunt, they anastomosed the azygos vein to a branch of the right pulmonary vein. In 1948 the first anastomosis was made; the results were most gratifying. At about this time, other groups [23,24,25] were taking a more direct approach and attacked the mitral valve directly thus reviving the earlier work of Cutler. Through a careful study of the function of the valve leaflets, they developed a technique which enables one to relieve the stenosis without producing regurgitation. Harken et al[28] emphasized that to establish a well functioning valve the aortic or major leaflet must be preserved. The major leaflet acts as a flutter valve and upon its integrity depends the competency of the valve. This function is illustrated in (Figure IV). The operation for mitral stenosis has now become more or less standardized and the results as reported by many different clinics are all most encouraging.

Summary

A summary of a few of the most dramatic advances in vascular surgery since 1938 has been presented and the present trends have been outlined.

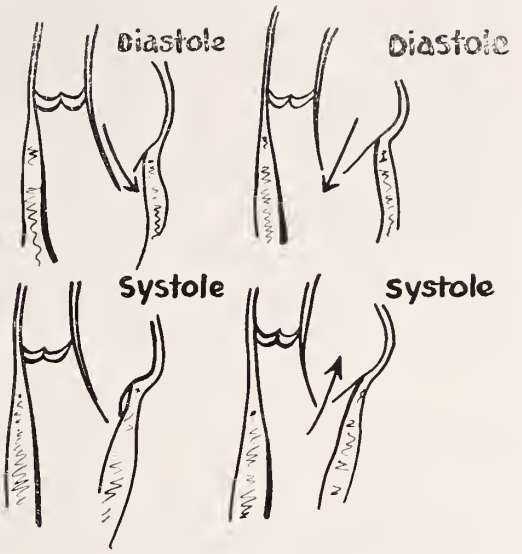


Figure 4. After Harken et al, Annals of Surgery, October 1951. The two diagrams on the left illustrate a mitral valve with a long intact aortic leaflet. The orifice points to the ventricular wall and has minimal regurgitation. The diagrams of the right illustrate a valve with a short aortic leaflet and a long minor leaflet. The orifice points into the outflow tract and there is marked regurgitation.

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Intestinal Obstruction

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Intestinal obstruction is a serious surgical condition in which successful treatment depends on early diagnosis and skillful management. The normal progress of the intestinal contents is interrupted thus producing local and systemic pathological changes. When recognized and treated in the early stages a successful outcome is to be anticipated but if therapy is not instituted until late in the course of the illness the result is often fatal even though the obstruction itself has been relieved.

Classification

Acute intestinal obstruction may be devided into two main types: (1) Mechanical and (2) Paralytic. In the former there is an actual organic blockage which prevents the intestinal contents from moving along through the lumen of the bowel. Mechanical obstruction may be further divided into simple and strangulating types. In the latter there not only is blockage to the passage of the intestinal contents through the lumen but there is also an impairment to the blood supply to a segment of bowel.

In the paralytic obstruction or paralytic ileus there is a cessation of the passage of the contents because of a lack of peristaltic action but there is no mechanical block to its progress.

Etiology

In the older writings statistical evidence showed strangulation of external herniae to be the most common cause but more recent reports confirm the belief that adhesions from previous operations are the most frequent causative factor. This can be explained by the increasing number of surgical procedures. Then too, fewer patients are neglecting surgical correction of their external hernia earlier in life.

There are many causes of mechanical obstruction and among these are stricture, cancer, adhesions, enteroliths and congenital bands[2]. There are extrinsic agents such as tumors of adjacent organs and abscesses. Those which interfere with the blood supply are strangulated herniae, volvulus, intussusception and mesenteric thrombosis. In the paralytic group are those cases of generalized peritonitis and, to a mild degree, following ordinary laparotomy. The ileus accompanying hypopottassemia is of this type.

Pathological Physiology

The effects are both local and systemic and the severity and rapidity of onset depend on whether or not the blood supply is occluded along with the intestinal lumen and on whether the obstruction is high or low[5]. In the beginning peristalsis is hyperactive in an attempt to force contents of the bowel through the narrow lumen. If the obstruction is not complete it soon will become so due to the resulting edema. The intestine above becomes dilated due to the accumulation of intestinal contents, swallowed air, and secretions from the injured gut. This dilatation compresses the vessels of the bowel wall causing anoxemia of the tissue and gangrene. If the obstruction is high, regurgitation and vomiting

Read before the Tri-County Medical Society Meeting (Clark, Bourbon and Madison) April 14, 1953.

take place early and the distension is less. Even though the abdomen may not show a great deal of distension in high obstruction, profound changes rapidly take place in the fluid and electrolyte balance. Dehydration occurs, with loss of chlorides and potassium in the vomitus and the patient quickly develops alkalosis, uremia, and hypopottassemia. When the obstruction is low, these alterations are delayed for a few hours but even then there is a great loss of fluid into the bowel, producing dehydration. Protein containing fluid lost into the peritoneal cavity also enhances the fluid loss.

Toxemia or the systemic effect is seen wherever there is impairment of the blood supply to the bowel wall. The pathogenesis of these effects is not easily explainable. Whether or not specific toxic substances are elaborated has long been debatable, and a great deal of research on animals has failed to elucidate the problem satisfactorily, nevertheless, absorption of toxic substances from the damaged bowel into the circulation undoubtedly takes place.

Diagnosis

Clinical Manifestations:

Pain—The dilatation of the gut causes pain and it is generalized and colicky in nature. At first the patient may consider it to be "gas" pains. It usually lasts 1 to 3 minutes and ceases only to recur at intervals of 3 to 10 minutes. There is usually complete relief in the interim.

Borborygmus—The peristaltic rush of the mixture of gas and air in a closed space causes the familiar gurgles at the height of the pain. As the bowel dilates more the sounds take on the tinkle of borborygmus.

Vomiting—This may be of two types—(a) Reflex vomiting which may accompany any acute abdominal disorder and (b) Regurgitant vomiting. Retrograde peristalsis arises from above the obstruction and intestinal contents are carried back into the stomach. After a few days this material has a fecal character but this does not mean that the obstruction is always low in the bowel. It only means that the material has been in the intestinal tract for a considerable time and it is a grave sign. The vomiting of feces does not occur in obstruction. If the blockage point is in the colon there may be no vomiting. The ileocecal valve may be so competent that a closed loop type of obstruction exists. Regurgitant vomiting which fails to relieve pain is always small gut obstruction. The higher the obstruction the more the vomiting and usually the less the pain.

Distension—This depends to a great deal on the level at which the obstruction has occurred. In those at a high level there will be less distension as the air and fluid are lost by the copious vomiting. Those low in the small bowel show marked distension as well as those of the colon. The passage of flatus or feces may take place from the bowel distal to the blockage point and may be misleading.

Signs of Strangulation—These are superimposed on those of simple obstruction. Due to the very mechanism of most of the strangulating types the onset is usually very abrupt with pain coming on suddenly. Local tenderness is present due to the injured bowel. If an external hernia, the mass is usually swollen, tender and reddened. If the involved section of bowel lies in the abdominal cavity there is tenderness, muscle spasm and rebound tenderness. A rising pulse rate, elevated temperature and leukocytosis warns of impending gangrene[6]. If a large segment of bowel is involved shock is likely to supervene.

Laboratory Data—Blood counts are not of aid in establishing an early diagnosis. Later they show only the effects of dehydration unless strangulation supervenes. A rising leukocyte count is very likely to mean the circulatory embarrassment has reached a critical stage[1]. A sharp rise in the pulse, temperature and leukocyte count is a bad omen. Determination of blood chlorides, NPN, CO_2 combining power and hematocrit levels is of value in proper management of the case.

X-Ray Examination—A flat plate of the abdomen is of great value[7]. It must be remembered that gas may normally be seen in the small bowel in infants and children up to about 3 years of age. In an adult it will usually not be found unless intestinal stasis occurs. The scout film taken with the patient lying supine will show the degree of distension and whether or not it is chiefly large or small bowel. If the distension is confined to the colon with no gas seen in the small bowel then a closed loop type of obstruction of the colon exists. If in addition distension of the small intestine is seen it means an incompetent ileocecal valve with regurgitation. Of course, if a paralytic type of ileus had supervened, gas would also be present here[3]. This point may be solved by

auscultation of the abdomen. At times it may be feasible to give an enema before taking the film and if no gas is then found in the colon obstruction may be assumed to be complete in the small bowel. An upright film of the abdomen in obstruction will show fluid levels but this information is of less value. A barium enema may be of help in either ruling out obstruction to the colon or in locating the lesion. However, the patient is frequently too ill or the bowel cannot be prepared sufficiently for satisfactory examination. Barium should never be given by mouth if the obstruction is thought to be beyond the pylorus as this may increase the degree of blockage by its presence.

Differential Diagnosis

At times it may be difficult to decide whether strangulation is present or whether there is simple obstruction caused by some inflammatory condition in the abdomen. Hysterical patients may present themselves complaining of abdominal pain and with abdominal distension. The great amount of swallowed air may show dilated gut but the lack of paroxysms of pain associated with the typical borborygmi usually helps to establish the true picture.

In acute pancreatitis there is usually a paralytic ileus but occasionally one may see dilated small intestine on the X-ray and also be able to hear typical peristaltic rushes associated with colicky pain. If it is fairly early in the disease blood amylase determination may be diagnostic.

It is of great importance to establish the diagnosis of intestinal obstruction. Once this is accomplished, it then becomes a differential problem to decide if strangulation is impending. It also is important to diagnose the cause. The presence of an abdominal operative scar or of an incarcerated hernia may be a very important sign. At repeated examinations one must not fail to continue to feel for a femoral hernia. It may not be noticeable on the first examination but a swelling may appear within the next few hours.

Prognosis

The earlier the diagnosis and the institution of proper treatment the better the outlook[4]. If the patient is seen late, with all the effects of dehydration and electrolyte imbalance present plus the toxic effects of a superimposed strangulation, then the situation is indeed grave. The over-all mortality rate in acute obstruction varies in different reports from 15 to 50%, the average being around 20%.

Treatment

Therapy of course depends on the type and location of the lesion. The first consideration is whether the obstruction is on a paralytic basis or is due to an organic occlusion. If it is found that one is dealing with a mechanical obstruction, then it is necessary to decide whether it is a simple obstruction or if strangulation is present. If it appears to be simple in type then one must further determine whether or not to try conservative measures or to proceed with operative treatment as soon as the patient's condition permits.

Non Operative Treatment

Intubation of the intestine either by an indwelling duodenal tube or by one of the longer intestinal tubes is indicated at the beginning. This decompression is necessary as a preliminary to operative treatment or may be used as definitive therapy in many cases. Conservative management is always risky in that the need for surgical intervention may arise at any time and so requires constant care and observation with repeated examinations for signs of strangulation. Leukocyte counts once or twice daily and an occasional repeat X-ray film are of aid. Obstruction caused by adhesive bands in the fairly early post operative period responds well to conservative treatment and may be permanently relieved.

If signs of strangulation appear, such as increased pulse rate, rising fever, increased leukocyte count, and localized tenderness, then operation is indicated. Conservative therapy should not be continued if the patient does not show adequate decompression in a reasonable time.

The signs of adequate decompression are:

(1) Decrease of pain and distention.

(2) Passage of gas, or stool.

(3) Absence of pain on discontinuing suction.

In colon obstructions gastro-intestinal suction is useful but should not be used as the sole treatment. Decompression by means of proximal colostomy or rarely by cecostomy is the method of choice. Many incomplete large bowel obstructions will begin to deflate within a few hours under conservative measures. This decompression is seldom adequate for definitive surgery but is useful in preparing the pa-

tient for investigative work in localizing the lesion.

Operative Treatment

Details of operative treatment depend on location and type of obstruction. Spinal anesthesia is the anesthetic of choice unless there is some specific contraindication. On opening the abdomen it is advisable to begin the exploration with the collapsed bowel below the obstruction rather than handling an already injured and distended intestine. Where this is technically impossible it may become necessary to exteriorize the distended loops in order to deal with the obstructing lesion, however, this evisceration should be avoided whenever possible. It is well to remember that there may be more than one point of obstruction and care should be taken not to overlook this condition. When there is extreme intestinal distension the value of enterotomy decompression[2] should be remembered.

The question frequently arises as to the viability of the involved intestine. The time-honored method of applying warm compresses, or administering 100% oxygen to the patient is well known to all of us. One recent addition has been the injection of 5 to 10 cc of 2% procaine into the mesentery of the suspected area. This relieves the vasospasm and serves as both a diagnostic and therapeutic measure. The return of normal color, peristaltic waves, and arterial pulsation is conclusive evidence of viability of the involved segment. In the event of nonviable bowel, resection and primary anastomosis are preferred. In complete obstructive lesions of the colon, proximal colostomy is the procedure of choice. This should be a simple loop colostomy which may be decompressed with a needle while the patient is still in the operating room and the bowel opened farther with the cautery in 18 to 24 hours.

Fluid and Electrolyte Replacement

The amount of dehydration and electrolyte imbalance may be determined by clinical observation and plasma chemistry values. Parenteral fluids are necessary to correct these abnormalities and at times may be urgent. Three important factors are concerned. These are to give adequate volume to restore the fluid balance, to replace the lost electrolytes, and to administer blood or plasma to correct the hypoproteinemia. As much as 2000 to 4000 cc may be necessary to cause the secretion of a dilute urine. Fluid administration is started with 5% glucose in isotonic saline. Alkalosis may be present and still persist in spite of adequate urinary output. In refractory cases hypopotassemia must be suspected. Potassium chloride 3 to 5 gm daily may be added to the fluids safely if the urinary output is adequate and the non protein nitrogen values of the blood are falling. A simple and inexpensive way of giving potassium parenterally is to add an ampule of 40 milliequivalents of potassium chloride to the flask of intravenous fluids. The latter should not be given rapidly.

Plasma may be lost in the obstructed bowel and nutritional edema may be added to an already edematous bowel. This may be corrected by plasma or whole blood administration.

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SPECIAL ARTICLES

THE PROBLEM OF FOREIGN-TRAINED PHYSICIANS

Licensure and medical care problems created by the heavy influx of foreign-trained doctors commanded a great deal of attention at the 50th annual Congress on Medical Education and Licensure in Chicago, February 7-9.

The three-day meeting attracted an unexpectedly heavy attendance of more than 600 medical educators and licensing and specialty board officials. The congress was sponsored by the American Medical Association's Council on Medical Education and Hospitals, the Federation of State Medical Boards of the United States and the Advisory Board for Medical Specialties.

"The infiltration of the medical profession of the United States by large numbers of doctors who have not been able to obtain a proper basic professional education is almost certain to lower the general level of practice in this country," Dr. Willard C. Rappleye, New York, dean of Columbia University College of Physicians and Surgeons, told the meeting.

"The numbers coming in are so large that they cannot readily be absorbed without that effect."

Dr. Rappleye pointed out that the United States government in fostering international good will, is admitting large numbers of displaced persons, including physicians about whose professional ability no questions are asked. More will be admitted by recent legislation which permits the entrance of several hundred thousands of immigrants above previous quotas, he said.

He added that unless this situation is met "with courage and the conviction that we shall not surrender the results of 40 years of effort in raising the standards of medical licensure, practice and education," we may revert to conditions resembling those of 50 years ago.

Dr. Stiles D. Ezell, Albany, secretary of the New York Board of Medical Examiners, said that except for Great Britain and the Scandinavian countries the last war brought destruction and degeneration to European medical education.

"Even before the elimination of the last of the unapproved medical schools in this country, there had begun a migration of physicians to this country which has now reached a total of more than 20,000," he stated. "The challenge in this fact is that the profession has not been prepared to understand what is involved in such a massive movement, nor has it realized the numerous deficiencies involved in the collective educational background of this group."

He pointed out that large numbers of foreign graduates have completed specialized training without any consideration of the deficiencies in their basic medical training or their eligibility for licensure.

Dr. Edward L. Turner, Chicago, secretary of the Council on Medical Education and Hospitals, recommended the adoption of a uniform plan for screening the professional competence of foreign-trained doctors.

Such a uniform procedure, Dr. Turner said, would be of greater assistance to state medical licensing boards than the present attempts to evaluate and list foreign medical schools. He pointed out that there are problems and difficulties in evaluating foreign medical schools which are "almost insurmountable."

Dr. Turner reported that the Council on Medical Education and Hospitals and the executive council of the Association of American Medical Colleges have compiled a list of 39 foreign schools which provide basic medical education on a par with that of approved schools in the United States, but said there are more than 550 medical schools in the world.

He said that while the council has endeavored to indicate that the absence of a school from this current listing does not indicate either approval or disapproval, but means primarily lack of adequate information, the absence of listing frequently serves to deny a graduate the right to examination before a state board.

"It seems advisable that there should be a careful analysis of state medical practice acts with serious consideration being given to the cooperative development of

some commonly acceptable yardstick or screening mechanism to evaluate competence of the foreign graduate," Dr. Turner stated.

He suggested that the National Board of Medical Examiners could become a highly effective aid to state boards in determining whether foreign-trained physicians were eligible for further state board consideration for licensure. The National Board, at the request of the state board, could conduct the examination for professional competency, and the state board could then determine if the candidate met other requirements for licensure, he added.

Dr. Edward J. McCormick, Toledo, president of the A.M.A., told the meeting that it was the responsibility of medical educators to instill a proper sense of moral values into the minds of medical students.

"Whether this is done by adding courses in ethics and moral principles to the curriculum, or through the medium of after-hours discussion groups, is a problem for the deans of medical schools to decide," Dr. McCormick said. "But, I am convinced that some concerted effort in this direction needs to be made."

He also expressed the opinion that a liberal arts background should be included in the pre-medical training of young doctors.

The financing of medical education was touched upon by two speakers. William C. Stolk, New York, president of the American Can Company and a trustee of the National Fund for Medical Education, reported that management is becoming alert to the vital significance of the 79 medical schools. Mr. Stolk said that business is accepting increased responsibility in helping to maintain high health standards and it realizes that financially solvent medical schools are a necessity.

Dr. H. G. Weiskotten, Shaneateles, N. Y., chairman of the Council on Medical Education and Hospitals, cited the progress in medical education and said that a new era was being entered—experimentation in undergraduate, graduate and post-graduate training of physicians without losing any of the gains already made.

Speaking on medical legislation, Dr. John N. McCann, Youngstown, O., retiring president of the Federation of State Medical Boards of the United States, said physicians must be brought to realize that a basic license to practice issued by a responsible state board is the sole guarantee of legal practice, not the examination given by a specialty board.

Dr. Frank B. Berry, Washington, assistant secretary of defense (health and medical), reported that the armed services need about twice as many medical officers as they now have, and that they hope to persuade graduates to take up such service as a career. Dr. Berry also said that "the chances are that from August to October, 1954, there will be a considerable number of doctors called into the armed services."

A panel on professional orientation brought out general agreement that most medical school graduates enter active practice with inadequate preparation and training in ethics, medical economics, doctor-patient relationships and social problems. Medical schools have the primary responsibility of providing such teaching, the panel members concluded, but they should have the help of medical societies and physicians in active practice.

Medical education should be regarded as a continuing process which lasts throughout a physician's professional career, rather than as something which is completed when a doctor receives his M.D. degree and his license to practice, it was stressed throughout a panel discussion of postgraduate medical education. Two problems which received special emphasis were how to reach physicians in small towns remote from medical centers and how to stimulate those who have no desire to leave their practice for postgraduate courses.

Medical societies have a definite responsibility to sponsor and advance postgraduate education in order to improve the caliber of medical service to the public, it was emphasized by one panel member. Another urged that teachers of postgraduate courses should have adequate previous experience to appreciate the needs of active practitioners. A third participant suggested that there is a rich area for experimentation in the field of home-study courses. There was general agreement on the need and value of participative courses which enable postgraduate students to work closely with teachers and patients in the demonstration of clinical problems.

The distribution of physicians in the United States is extraordinarily good, according to Frank G. Dickinson, Ph.D., Chicago, director of the A.M.A. Bureau of Medical Economic Research, who made a

(Continued on page 296)

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EDITORIALS

ACTIVE IMMUNIZATION AGAINST POLIOMYELITIS

Experimental vaccination for polio is not new. In 1910 the first successful vaccination of a monkey was reported by the renowned Louisvillian scientist, Simon Flexner. His tests implied that some day it would be possible to immunize against poliomyelitis; his method had no hope of human application for he gave 18 subcutaneous injections of live virus over a period of seventy days! But a big first step was taken. One of the many scientists who shed fundamental light on resistance to poliomyelitis was W. Lloyd Aycock of the University of Louisville Class of 1919. These great scientists had to leave Kentucky to pursue their work since for a long time the only virological research done here concerned the economically more important diseases of plants and animals! How pleased these two great departed men would be to know that the Kentucky Child Health Foundation has recently established a laboratory in the University of Louisville for research in the virus infections of children including studies on poliomyelitis.

With the progressive accumulation of knowledge it became clear that at least three major immunological types of poliomyelitis virus occur in Nature. To be absolutely protected one must have antibodies in the circulating blood against all three—types 1, 2, and 3, formerly called Brunhilde, Lansing and Leon types; the type 1 strains cause most epidemics. As a result of natural exposure, approximately 99% of the adult population achieve immunity without having displayed paralysis. Any vaccine proposed as a method of artificial immunization should duplicate or better what Nature does, i.e., immunize 99% of the population by adult life without incurring the risk of paralysis in 1 to 100 or 1 to 1000 individuals which is Nature's price for immunity in many parts of the world.

As yet there is no safe effective vaccine available for use. Four possible virological approaches are 1) A "killed" polyvalent vaccine—similar in principle to the polyvalent influenza vaccine; 2) A living stable laboratory developed non-virulent mutant strain of virus—such has been used successfully in yellow fever for many years; 3) Discovery of a virus in the animal kingdom which is antigenically closely related to poliomyelitis yet not dangerous for man—a prime example is the original cowpox virus of Jenner; 4) Deliberate administration of live virus under the protective cover of injected antibody (gamma globulin);—I know of no virus examples of the latter in human medicine but this is the method which had been widely used in the prophylaxis of canine distemper virus infections of dogs.

Through the years most of the vaccine research has related to "killed" virus. Physical methods of killing the virus have included heat, dessication, ultrasonic and electron bombardment and ultraviolet application. With the exception of ultraviolet, the resulting preparations were inert as immunizing agents. Chemical methods have included phenol, aluminum hydroxide, glycerol, tannic acid, chloroform, potassium chlorate, sodium ricinoleate, nitrogen mustards and formalin. Of these, only formalin appeared to hold some promise of yielding a non-infective preparation which still had some immunizing capacity.

In 1935 Brodie published his observations on a formalin "killed" poliomyelitis vaccine used in monkeys and subsequently in an uncontrolled study of approximately 9,000 humans. Brodie had shown that formalin may kill off the poliomyelitis virus without necessarily destroying its antigenic capacity. The dilemma is this—that mixing virus and formalin for too long or in excess amounts may cause the preparation to be inert; if not enough formalin or time of admixture is used, the material may remain infective. The margin is not broad, hence rigorous safety tests are essential. At the same time Kolmer's "attenuated" poliomyelitis vaccine was used in children. It is widely believed that a few of the children who developed poliomyelitis following injection with these "killed" or "attenuated" vaccines were infected by the vaccine, with paralysis commencing in the injected arm. Although still a medical student at that time, the writer recalls how bitter the disap-

pointment when the much publicized anticipations for "The Vaccine" were not realized. No serious effect upon the profession's prestige or the public's confidence ensued, in part perhaps because of the coincidental beginnings of the halcyon days of prontosil and the early sulfonamides. Two other drawbacks of those vaccines were a) they contained monkey nervous tissue, thereby introducing a risk of allergic encephalomyelitis and b) that only one of the (now known) three types of poliomyelitis virus was present in the vaccines.

In the conquest of poliomyelitis the greatest single achievement has been that of Enders, Weller and Robbins,—namely growth and identification of all three types of the virus in tissue-cultures. This meant many things to research and developmental workers—including a method of growing large amounts of the virus free of monkey nervous tissue.

At the present time there is great interest in a formalin treated tissue-culture fluid vaccine. The principle is identical with the manufacture of polyvalent influenza virus vaccine except that the infective fluids come from tissue cultures instead of embryonated eggs. The tissue cultures consist of kidney epithelium grown out from pieces of rhesus monkey kidneys. Poliomyelitis viruses of the three known types are pooled together, treated with formalin and then tested for safety by the inoculation of tissue-culture tubes, monkeys, and other sterility tests.

The resultant material has been developed in Dr. Salk's laboratory; his tests have indicated that it is safe and evokes type-specific antibody responses in human recipients, particularly in those with some pre-existing antibody. Optimum injection and booster intervals must be worked out by field study.

A non-discerning headline reader could easily but erroneously believe that the "battle is o'er." That developmental wrinkles are numerous is clear from the changes being made in the vaccine's composition and the proposed method for its evaluation in human trials. As recently as the November 1953 issue of the American Journal of Public Health it is indicated that mineral oil adjuvant (to boost the antigenic response) is added to the vaccine. According to Life Magazine, the proposed vaccine is now aqueous instead of oily.

Lay impressions gained from radio and press have led many to the conclusion that there is now a suitable vaccine for poliomyelitis. Thus the cover of LIFE reads "How Polio Vaccine Was Found," in the past tense; the magazine's date is February 22, a date coupled in each schoolboy's mind with veracity. As doctors, our fervent hope is that prescience and veracity are therein combined. The exact position is that a massive laudable experiment is to be launched. The same relative situation was maintained recently with regard to gamma-globulin in the *passive* prophylaxis of polio. The recent sobering accounts of this preparation in polio point up the fact that while we must never suspend Hope, we must suspend Judgement in the face of experiments.

An important question which the proposed experiment should answer over the course of years is whether "immunity" from the "killed" vaccine is enduring or short-lived. If short-lived (as is generally expected of killed virus vaccines) it may be enhanced by repeated natural "booster infections," or may otherwise require repeated inoculations throughout life. Under these conditions the development of nephrotoxic effects due to acquired sensitivity to monkey kidney proteins might require study. The authorities of each State, as in Kentucky, are weighing all of these factors carefully, plus the timing of the inoculations to avoid the poliomyelitis season. A bold scientific experiment is being lined up, which calls for the care and judgement physicians worthy of the name are expected to apply.

Of the other three major potential approaches to active immunity to polio mentioned above, the development in the laboratory or the discovery de novo in Nature of nonparalytogenic virus variants of the 3 types could represent an answer by providing enduring immunity. If given by the natural route of polio infection, i.e., orally, certain hazards would be eliminated. Such approaches, too, are in the research realm, but as yet not ready for extensive human trial.

The prospect for an effective practicable vaccine has never been brighter providing the research lamps are permitted to burn aplenty. So much basic polio research remains to be done that it is hoped more rather than fewer laboratories will be enabled to carry on. Under these conditions, many of the readers of this issue may live to see the development of a safe effective enduring vaccine for poliomyelitis.

Alex J. Steigman, M. D.
Professor of Child Health
University of Louisville
School of Medicine

President's Page

Your Program Committee would like to report some of its plans to you at this time. The outstanding innovation will be separate meetings on Wednesday afternoon by some seven or eight specialty groups. Our society is too small to have it broken up into numerous sections. The majority of papers should be of general interest and most of the time allotted to the general sessions. This plan will be followed except on Wednesday afternoon.

At that time each specialty group will arrange its own program with one outside speaker who will give a second talk to a general session. Every specialty group meeting will be open to any members of the State Society. All groups will meet in the Columbia Auditorium making it possible for a member to listen in on several programs during the afternoon should he so desire.

While the papers presented before these groups will necessarily be more specialized than those before the general sessions, they will give an opportunity for the general practitioner to keep abreast in the field or fields that are of special interest to him. Should the plan be well received as anticipated, other groups could be added the following year.

It is felt that this plan will stimulate attendance and add to the instructive and social opportunities of the meeting. So far as the general sessions are concerned, emphasis will be placed upon clinical and practical presentations. It is not too early to make your plans to attend the Annual Meeting, September 21, 22 and 23.



President

ORGANIZATION SECTION

Plans Completed for Officers Conference, April 15

"How Can the County Medical Society Best Serve the Public?" will be discussed by Walter B. Martin, M.D., Norfolk, Virginia, president-elect of the AMA, featured luncheon speaker at the Fourth Annual County Society Officers Conference, Phoenix Hotel, Lexington, April 15.

Another highlight of the program will be five KSMA members participating in a panel discussion entitled, "How My County Society Does It," moderated by Mr. Jean Clos, Louisville, executive secretary of the Jefferson County Medical Society, who has had wide experience in the field of radio-panel work.

Participating members of the panel are: Charles Rutledge, M.D., Pikeville; Walter R. Johnson, M.D., Paducah; Robert J. Hoffman, M.D., South Fort Mitchell; Charles M. Francis, M.D., Bowling Green, and Richard G. Elliott, M.D., Lexington.

J. Duffy Hancock, M.D., Louisville, president of the KSMA, said the program had been planned to be of special interest to all county society officers, county commiteee chairmen, officers and councilors of the KSMA, members of the House of Delegates, KSMA committee chairmen, and board members of the Woman's Auxiliary.

In addition to Dr. Martin, seven other top-flight, nationally recognized men will also appear on the program which promises to contain presentations of broad practical appeal. They are Louis M. Orr, M.D., Orlando, Florida; Percy E. Hopkins, M.D., Chicago; Frank E. Wilson, M.D., Washington, D.C.; Arthur J. Roser, M.D., Fort Wayne, Indiana; Richard S. Graves, M.D., Dayton, Ohio; Mr. Arthur Tiernan, Evansville, Indiana, and Mr. Russell Staudacher, Chicago.



Dr. Orr



Dr. Hopkins



Phoenix Hotel—Site of the Conference

Long active in organized medicine, Dr. Martin, a 1916 graduate of Johns Hopkins University School of Medicine, has served as a delegate to the AMA, has been a member of the Council on Medical Service and a member of the Board of Trustees since 1946. He began practicing internal medicine in Norfolk in 1919, where he is now Chief of the Medical Service at the St. Vincent De Paul Hospital and a consultant in internal medicine at the U. S. Public Health Service Hospital.

KSMA to Assume Operation of M.D. Placement Service

The activities of the Physicians Placement Service, which has been operated by the State Department of Health in cooperation with the Kentucky State Medical Association since its inception in 1948, are being transferred to the association, according to Ralph D. Lynn, M.D., Elkton, chairman of the KSMA Physicians Placement Committee.

His group voted to begin taking over the operation of the placement service when the committee met in Louisville, February 18, 1954.

"After our committee discussed this matter with the Secretary and General Manager, Bruce Underwood, M.D., Louisville, who is also State Commissioner of Health, and following action of the Executive Committee of the

(Continued on page 282)

Program

Fourth Annual County Medical Society Officers Conference

Phoenix Hotel, Lexington **Thursday, April 15, 1954**

9:15 A. M. Pre-meeting showing of movie

MORNING SESSION

Fireside Room

J. Duffy Hancock, M.D., presiding

President, Kentucky State Medical Association

9:45 **Call to Order and Announcements.** Dr. Hancock

9:50 **Welcome and Remarks.** Rankin Blount, M.D., President, Fayette County Medical Society

9:55 **Greetings from the Headquarters Office.** Bruce Underwood, M. D., Louisville, Secretary and General Manager, KSMA

10:00 **"The M.D. as a Public Speaker"**
Richard S. Graves, M.D., Dayton, Ohio
County Public Relations Chairman

10:20 **"The AMA on Capitol Hill"**
Frank Wilson, M.D., Washington, D. C.,
Director, AMA Washington Office

10:45 **"A Meeting With Labor"**
Arthur J. Roser, M.D., Fort Wayne, Indiana
President-Elect, Fort Wayne Medical Society

11:05 **Intermission**

11:10 **"The County Society Presents the Medical Forum"**
Arthur P. Tiernan, Evansville, Indiana
Executive Secretary, Vanderburg County Medical Society

11:35 **"How My Society Does It"** (Panel of five KSMA County Society Officers)
Jean Clos, Executive Secretary
Jefferson County Medical Society, Moderator

12:00 **Discussion**
J. Farra Van Meter, M.D., Lexington
Chairman of the Council

12:30 **LUNCHEON SESSION, BALL ROOM**

1:30 **"How Can the County Medical Society Best Serve the Public?"**
Walter B. Martin, M.D., Norfolk, Virginia
President-Elect, American Medical Association

AFTERNOON SESSION

Ball Room

Clyde C. Sparks, M.D., presiding

President-Elect, Kentucky State Medical Association

2:00 **"Should M.D.'s Support All Forms of Voluntary Health Insurance"**
Percy E. Hopkins, M.D., Chicago, Illinois
AMA Council on Medical Service

2:20 **"SAMA—Spanning Medical Education with Medical Practice"**
Russell Staudacher, Executive Secretary
Student American Medical Association

2:25 **"Government Medicine, VA Style"**
Louis M. Orr, M.D., Orlando, Florida
Chairman, AMA Committee on Government Services

2:55 **Discussion and Adjournment**

(Continued from page 280)

KSMA Council, it was decided that the functions of the Physicians Placement Service should be under the direction of our committee," Dr. Lynn said.

"Those cases that have been accepted and are being processed by Mrs. Ray Wonderlich, who has rendered such effective service when it was under the jurisdiction of the Health Department, will be completed by her," Dr. Lynn stated. He indicated that all requests in the future would be handled by his committee.

Getting the community that needs a physician and the doctor seeking a location together is the chief function of the committee, Dr. Lynn pointed out. A previously tested formula will be used by his committee in determining communities with the greatest need.

Dr. Lynn said all county societies would be contacted and he urged their cooperation in providing his committee with information with which the committee might apply the formula to set up the priority of community needs.

In addition to Dr. Lynn, other members of the committee who attended the meeting include: J. Ewing Dunn, M.D., F. Hays Threlkel, M.D., Keith Crume, M.D., G. L. Dyer, M.D., and Thomas Averitt, M.D.

President Urges Tardy Members To Remit Annual Dues

To those members who have overlooked remitting their 1954 annual KSMA dues, this, the April issue, will be the last Journal that will be received until their membership fees have been recorded in the headquarters office, according to J. Duffy Hancock, M.D., Louisville, KSMA president.

"In addition to losing your subscription to our improved Journal," Dr. Hancock said, "those who overlook paying their dues jeopardize coverage under their professional liability policies, may cause loss of hospital staff privileges, and automatically withdraw their support from the all important aims of organized medicine."

The president stated that Chapter IX, Section 2, of the by-laws of the association obligates all members to remit their dues to their county medical society secretary in time for the secretary to report to the headquarters office on or before April 1, 1954.

"It is most encouraging to state at press time the collection of our 1954 annual KSMA dues is running ahead of our best year in the last five. We are all grateful for this expression of confidence in the management of the association, and for the vigor of the interest illustrated by the support given to the association's expanded program," Dr. Hancock reported.

(Continued from page 280)

New Orleans M.D. to Address Ky. Surgical Society, May 15

I. Mims Gage, M.D., of New Orleans, will discuss "Chronic Pancreatitis" at the fifth annual meeting of the Kentucky Surgical Society as its guest speaker, Saturday, May 15, 1954, at French Lick, Indiana. W. Vinson Pierce, M.D., Covington, is president of the society.



Dr. Gage

According to Francis M. Massie, M.D., Lexington, secretary, who made the announcement, other participants and the subjects they will discuss on the tentative scientific program are as follows:

Harold F. Berg, M.D., Louisville, "The Use of Radioisotopes in Surgery;"

John B. Floyd, Jr., M.D., Lexington, "Acute Pancreatitis (an experimental study);"

Joseph E. Hamilton, M.D., Louisville, "A Comparative Study of Vagotomy and Subtotal Gastrectomy for Duodenal Ulcer;"

Coleman C. Johnston, M.D., Lexington, "The Changing Attitude Towards Diverticulitis."

Other activities of the French Lick Session include a meeting of the Council and an election of officers.

The guest speaker, Dr. Gage, who received his degree in 1917 from Tulane University of Louisiana School of Medicine, is a senior visiting surgeon at Charity Hospital, New Orleans, and a consultant on the staff of several other Louisiana hospitals. He is a Professor of Clinical Surgery at Tulane. In World War II, Dr. Gage was a Colonel in the Medical Corps of the United States Army.

The Kentucky Surgical Society is composed of 100 members, 23 of whom were elected last year at the fourth annual meeting in May, bringing the present membership to its limited quota.

In addition to Dr. Pierce, former vice-president and now president of the society and Dr. Massie, secretary, other officers are: Pat R. Imes, M.D., Louisville, chairman of the Council, and R. Arnold Griswold, M.D., Louisville, vice-president.

The society recently made an appropriation of $1,000 to the McDowell Home, the second gift which has contributed to the shrine. In 1953 an appropriation of $720 was received from members through voluntary subscriptions. Dr. Massie stated that because of the society's deep interest in the project, the substantial support will be continued.

New Scientific Program Plans Announced by KSMA Committee For 1954 Annual Meeting, Louisville, September 21, 22, 23

Outstanding Specialists to Address Nine Individual Groups and General Sessions

Aiming at developing greater interest in more member groups, and, at the same time providing an opportunity for more members to participate, the Committee on Scientific Assembly recently announced its carefully drawn plans for the scientific program at the 1954 Annual Meeting, which, it is felt, will be highly profitable to all KSMA members, Committee Chairman J. Duffy Hancock, M.D., Louisville, reported.

The 1954 session will be held Tuesday, Wednesday and Thursday, September 21, 22 and 23, at the Columbia Auditorium in Louisville. The innovation is planned for the Wednesday afternoon meeting. Dr. Hancock said the plan would work like this:

Instead of having the customary general session, Wednesday afternoon of the 22nd, nine specialty groups will conduct individual programs simultaneously. Each of these specialty groups has invited a nationally known speaker in their specialty to address them that afternoon. These visiting essayists will also speak at one of the general sessions on Tuesday, Wednesday morning, or Thursday.

In addition to the top-flight guest essayists, each group will select three outstanding Kentucky physicians to round out the afternoon programs. The customary break of thirty minutes to visit the exhibits will be observed.

"The Wednesday afternoon program will enable specialty groups to present highly technical discussions and at the same time offer more KSMA members an opportunity to take part in the scientific sessions. An attending member will be free to move from group to group as his interest leads him," Dr. Hancock pointed out.

"Since the guest essayists are also addressing the general sessions, presentations given here by the visiting gentlemen will be directed to the top general practitioner level," the chairman stated. He said he had been delighted with the enthusiasm shown with the announcement of the new program.

The nine specialty groups participating in the scientific program of the KSMA Annual Meeting are: The American College of Physicians, (Kentucky Group); Kentucky Chapter, American Academy of General Practice; Kentucky Chapter, American Academy of Pediatrics; Kentucky Chapter, American College of Chest Physicians; Kentucky Eye, Ear, Nose and Throat Section of the KSMA; Kentucky Obstetrical and Gynecologic Society; Kentucky Psychiatric Association; Kentucky Society of Anesthesiologists, and the Southeastern Surgical Congress.

Pediatric Postgraduate Course to Begin May 6, Louisville

The Pediatric Postgraduate Course, sponsored by the Kentucky State Medical Association, the University of Louisville and the American Academy of Pediatrics will be held at the new Children's Hospital from Thursday, May 6 through June 24, 1954.

The sessions will run for three consecutive hours beginning at 9:30 a.m. until 12:30 p.m. each day. W. W. Nicholson, M.D., Louisville, has made the announcement that all attending members of the American Academy of Pediatrics will be given credit for this course.

The complete program is as follows:

PROGRAM

Pediatric Postgraduate Course
Children's Hospital Louisville
May 6 - June 24, 1954

Thursday, May 6

Prophylaxis in Rheumatic Fever
Joseph A. Little, M. D.

Clinical Conference
James W. Bruce, M.D.

Discussion by
Lee Palmer, M.D.

Hip Disease in Children
Lawrence A. Davis, M.D.

Thursday, May 13

Tumors of Childhood
Israel Diamond, M.D

Clinical Conference
Leonard T. Davidson, M.D.

Discussion by
Owen S. Ogden, M.D.

The Use of Gamma Globulin
Alex J. Steigman, M.D.

Thursday, May 20

Congenital Heart Disease and Cardiac Surgery
Joseph A. Little, M.D.

Clinical Conference
Leonard T. Davidson, M.D.

Discussion by
E. Paul Scott, M.D.

Common Respiratory Disease
Alex J. Steigman, M.D.

Thursday, May 27

Emotional Aspects of Well Baby Care
Henry H. Work, M.D.

Clinical Conference
Leonard T. Davidson, M.D.

Discussion by
Margaret A. Limper, M.D.

Infectious Hepatitis
Alex J. Steigman, M.D.

Thursday, June 3

Pediatric Urology
Robert Lich, M.D.

Clinical Conference
Leonard T. Davidson, M.D.

Discussion by
Harry S. Andrews, M.D.

X-Ray Conference
Lawrence A. Davis, M.D.

Thursday, June 10

Dehydration and Starvation in Diseases of Childhood
William A. Brodsky, M.D.

Clinical Conference
Leonard T. Davidson, M.D.

Discussion by
Martin J. Harris, M.D.

Symposium on Advances in Pediatric Surgery
Hugh B. Lynn, M.D.

Thursday, June 17

Dehydration and Starvation in Diseases of Childhood (concluded)
William A. Brodsky, M.D.

Clinical Conference
Leonard T. Davidson, M.D.

Discussion by
Walter A. Kirchner, M.D.

Diagnosis and Therapy of Tuberculosis in Childhood
Joseph A. Little, M.D.

Thursday, June 24

Anemias of Childhood
Israel Diamond, M.D.

Clinical Conference
Leonard T. Davidson, M.D.

Discussion by
Selby V. Love, M.D.

Minor Pediatric Surgery
Hugh B. Lynn, M.D.

Industrial Health Congress Draws 400 to Louisville

Over 400 physicians, management representatives and labor leaders, representing an excellent proportion of industrial sections of the U. S., attended the 14th Annual Congress on Industrial Health, held at the Brown Hotel, February 24-25, 1954.

The Congress, which met under the sponsorship of the American Medical Association's Council on Industrial Health, threw new light on the problems encountered in the maintenance of the health of factory and white-collar workers.

J. Duffy Hancock, M.D., Louisville, KSMA president, served as presiding officer over the opening general session, February 24. J. Murray Kinsman, M.D., dean of the University of Louisville School of Medicine, spoke on "Rehabilitation in Louisville" at the Annual Dinner with the Jefferson County Medical Society at which David M. Cox, M.D., Louisville, president of the Jefferson County Medical Society, presided.

A considerable portion of the program was devoted to panel discussion, one of which emphasized the stress effects on workers in industry. Another group discussed the effect of prolonged illness.

Gradie Rowntree, M.D., Louisville, member of the AMA Council on Industrial Health, and chairman of the KSMA Committee on Industrial Medicine and Surgery, served as general chairman of the Congress.

Heart Catheterizing Pioneer M.D. Lectures in Louisville

The first physician ever to catheterize a human heart in the U. S., Andre Courand, M.D., professor of medicine at Columbia University's College of Physicians and Surgeons, presented a series of lectures in three Louisville hospitals, March 3-6.

Heart catheterization was first used in the United States in 1940, and is now being extensively practiced at Louisville General Hospital to appraise heart damage. It is often used in determining whether a patient's heart is healthy enough to allow the patient to undergo surgery, Dr. Courand stated.

The French physician, who spoke at General Hospital, Veterans Hospital, and Children's Hospital, won the John Phillips Memorial Award in 1952 for outstanding work in internal medicine.

House to Present Two Awards at 1954 Annual Meeting

KSMA awards will be made to two outstanding members of the association at the Annual Meeting, September 21-23, 1954, the recipients to be selected by the House of Delegates at its first meeting.

Top award is the KSMA Distinguished Service Medal, which has been presented each year since its inception in 1945. Last year the medal was awarded posthumously t R. Haynes Barr, M.D., Owensboro, 1953 KSMA president who died in office, May 5, 1953.

The other award to be presented is the Outstanding General Practitioner Award, received in 1953 by Joseph I. Greenwell, M.D., of New Haven, who was also the winner of the annual general practitioner award presented by the AMA.

Any county medical society or member of the association may submit nominations to the headquarters office, 620 South Third Street, Louisville. The nominations will be reviewed by the Council and final selection will be made by the House of Delegates.

New Sections and Faculty Members Added to U of L Med. School

Three new sections have been established at the University of Louisville School of Medicine, according to J. Murray Kinsman, M.D., dean: (1) Cardiovascular Diseases with Herbert L. Clay, M.D., as Chief, (2) Diseases of the Chest with Oscar O. Miller, M.D., as Chief, and (3) Gastroenterology with Sam A. Overstreet, M.D., as Chief. All three physicians are residents of Louisville.

"Of equal importance are the new faculty promotions and appointments," Dr. Kinsman continued, "who include: J. Andrew Bowen, M.D., promoted from Associate Professor to Professor of Urology in the Department of Surgery; John P. Bell, M.D., from Associate to Assistant Professor of Psychiatry; Joe L. Lawson, M.D., from Instructor to Assistant Professor of Medical Psychology in the Department of Psychiatry, and Charles H. Crudden, M.D., from Instructor to Assistant Professor of Psychiatry."

Dr. Kinsman also announced the promotion of Alex J. Steigman, M.D., to Chairman of the Department of Pediatrics, more complete details of which are carried elsewhere in the Journal on page 288.

The following Postdoctoral Fellows have been appointed: John Hurley, M.D., Sander Klein, M.D., and David Stewart, M.D., in the Department of Psychiatry; Harold Earl Kleinert, M.D., formerly Chief Surgical Resident of Grace Hospital, Detroit, Michigan, in the Department of Surgery and Roger A. Melick of London, England, in the Department of Medicine.

New appointments include: Ernest R. Seitz, M.D., Veterans Administration Hospital, Louisville, as Assistant Professor of Radiology; Murray M. Lipton, M.D., formerly Associate in the Division of Immunology, Public Health Research Institute of the City of New York, as Assistant Professor of Child Health Research in the Department of Pediatrics; and Walden R. Smith, M.D., formerly Chief Anesthesiologist at Camp Gordon, Georgia, as Assistant Professor of Anesthesiology in the Department of Surgery.

Rural Health Group Advised To Try Self-Help

Knowing their own resources and abilities, Kentucky citizens themselves can best administer to individual and community health needs through proper application of safety in the farm and home, proper care of farm animals, and many non-medical and medical principles, according to speakers who addressed representatives of 41 counties, at the all-day session of the Third Annual Kentucky Rural Health Conference in Louisville, March 10.

Wyatt Norvell, M.D., New Castle, chairman of the KSMA Rural Health Committee, was elected chairman; Miss Myrtle Weldon, Lexington, state leader of Home Demonstration Agents, extension division, Kentucky College of Agriculture, was re-elected vice-chairman; Mrs. Thomas E. Roberts, Louisville, state director of Farm Bureau Women, was elected secretary.

Farm men and women, educators, parents, members of the medical, dental and nursing professions, in addition to other groups heard out-of-state and Kentucky leaders discuss community accomplishments that are possible through function of rural health councils.

Keen Johnson, former governor of Kentucky, speaking at the banquet meeting on "Health Is Everybody's Business" emphasized that health is far more than a responsibility of physicians, dentists, nurses, veterinarians, public health workers and others professionally concerned with the problem. It is in large measure the responsibility of every layman both in his organizations and as an individual.

Another prominent guest speaker was F. R. Willsey, Lafayette, Indiana, who appeared on a symposium on "Farm and Home Safety." Mr. Willsey spoke from wide experience as Farm Safety Specialist at the Extension Division of Purdue University.

Members of the KSMA who appeared as speakers and discussion leaders at the conference were J. Duffy Hancock, M.D., Louisville,

president; Bruce Underwood, M.D., Louisville, secretary and general manager; Wyatt Norvell, M.D., New Castle, chairman of the KSMA Rural Health Committee; Walter L. O'Nan, M.D., Henderson, chairman of the Kentucky Rural Health Council; Wendell Hurt, M.D., Scottsville; Mildred E. Gabbard, M.D., Booneville; and Donald Graves, M.D., Frenchburg.

The program also included discussions on such topics as voluntary health insurance, nursing shortages, medical scholarships and how these and similar matters may be handled through local rural health councils.

Public Health Association to Meet May 19-21, in Louisville

"Strengthening Local Health Departments" will be the theme of the annual convention of the Kentucky Public Health Association at the Seelbach Hotel, Louisville, May 19, 20 and 21. Sam Moore, Greensburg, public health administrator for Green County and Adair County Health Departments is president.

Two KSMA officers, J. Duffy Hancock, M.D., president, and Bruce Underwood, M.D., secretary and general manager, will speak at the meeting's opening session. Governor Lawrence Wetherby is also scheduled on the program.

Other highlights of the three day convention include an election of officers and a banquet at the Seelbach, Thursday evening, May 20. Miss Mary A. Gallagher, public health nurse for Oldham County, will be installed as president.

Anyone interested in public health is invited to attend. Associate membership in the Kentucky Public Health Association can be obtained by paying dues of one dollar.

Close to 600 health officers, sanitarians, nurses, administrative personnel, guests and others attended the 1953 convention held in Louisville last April.

Credentials Committee Selected

Speaker of the House Charles A. Vance, M.D., Lexington, who will preside over the Special Session of the House of Delegates to be held at the Phoenix Hotel in Lexington, Thursday, April 15, has announced his appointees to the KSMA Credentials Committee that will serve at the Special Session.

The following were appointed: J. P. Wyles, M.D., Cynthiana, chairman; H. C. Denham, M.D., Maysville, and Paul Harrison, M.D., Owenton.

Attention: Scientific Authors; Editor Makes Suggestions

In reply to requests and to assist authors in planning their material for the improved scientific section of the KSMA Journal, the following suggestions have been made by the Editor and his Advisory Committee.

Manuscripts should be submitted in duplicate, an original and one carbon, and typed with double spacing. Maximum length of an article should not exceed 4500 words, and the Board of Consultants on Scientific Articles prefers that they be briefer than this when possible.

All scientific material appearing in the Journal is reviewed by the Board of Consultants on Scientific Articles. If illustrations are submitted with a paper, the Journal will assume the cost for the first three one-column width half tones. The cost of additional illustrations will be borne by the essayist.

Arrangements for reprints of an article should be made directly with the publisher of the Journal, Mr. J. G. Denhardt, Times-Journal Publishing Company, Bowling Green, Kentucky.

Please mail your scientific articles to the Journal of the Kentucky State Medical Association, 620 South Third Street, Louisville 2, Kentucky.

Health Insurance Keynoted at Rural Health Conference

"Voluntary Health Insurance" was one of many important topics emphasized in the well-rounded program of the Ninth National Conference on Rural Health, held at the Baker Hotel, Dallas, March 4-6, promoting the challenging theme, "Let's Put More 'U' in Community."

An entire afternoon session including top-flight speakers and a discussion period was devoted to the "What, How and Why" of health insurance.

Chief speaker of the conference was AMA President Edward J. McCormick, M.D., Toledo, who discussed "Our Investment in Rural Health," climaxing the luncheon session. Dr. McCormick praised the 700 agricultural and medical leaders attending the conference for their efforts in promoting cooperation between the medical profession and the rural health groups.

He pointed out the activities and accomplishments the physicians placement program has made in many rural communities and the extent to which the AMA and its Council on

Rural Health has endeavored to expand this important activity.

The Texas Physician Placement Committee reported in 1953 it had placed 38 general practitioners in rural communities and the number of applicants in 1954 had almost doubled.

Another highlight of the conference was a personal story unfolded by J. Paul Jones, M.D., Camden, Alabama, who alone financed a 14-room clinic and convinced the town of the value of providing improved medical facilities.

Dr. Kleinert Addresses First Councilor District

"Cancer of the Oral Cavity" was the subject discussed by Harold Kleinert, M.D., director of the Cancer Clinic of the Louisville General Hospital, at a meeting of the First Councilor District of the KSMA, Wednesday, March 17.

J. Vernon Pace, M.D., Paducah, councilor, who made the announcement, said the guest speaker, Dr. Kleinert, who is a Research Fellow in Surgery at the University of Louisville School of Medicine, presented a most enlightening and profitable discussion.

George McClain, M.D., Benton, president of the Marshall County Medical Society, the host group, presided over the evening dinner session held at the restaurant at Kentucky Dam Village State Park, Gilbertsville.

Secretary of the Marshall County Society, S. L. Henson, M.D., Benton, assisted in making the arrangements for the meeting, Dr. Pace said. The last meeting of the district was held February 11, 1954, at Murray State College.

Appointees Named to Serve on New Committees

At the February 4th meeting of the Executive Committee of the Council, the president of the KSMA, J. Duffy Hancock, M.D., Louisville, was authorized to appoint a Committee on Cerebral Palsy and a KSMA Diabetic Committee. Appointees named by Dr. Hancock were:

Committee on Cerebral Palsy

Orville Miller, M.D., Louisville, Chairman
Frank Duncan, M.D., Monticello
Irving A. Gail, M.D., Lexington
Richard Grise, M.D., Bowling Green
V. F. Voss, M.D., Louisville

KSMA Diabetic Committee

Ben Hollis, M.D., Louisville, Chairman
Thomas Hobbs, M.D., Lexington
Thomas Gilbert, M.D., Bowling Green
Wendell Lyon, M.D., Ashland
Edward J. Stratman, M.D., Fort Thomas

Kentucky Physicians Invited to Join Indiana Hawaiian Tour

A ten day flight tour of Hawaii following the San Francisco meeting of the AMA is being offered to Kentucky physicians by the Indiana State Medical Association, according to Mr. James A. Waggener, Indianapolis, executive secretary.

He said the trip will be made by Pan American Clipper leaving San Francisco the night of June 25, and returning to Los Angeles July 5. Cost of the trip is set at $655 round trip, per person, leaving from Indianapolis, or $455 if the tour is begun in California.

Entertainment will be provided for wives while physician-husbands are attending medical sessions on the island.

One of the special highlights is a sight seeing tour around the island climaxed by an evening at the Queen Surg Luau, traditional and lavish Hawaiian feast including festival island music and Hawaiian dancers.

Since space is limited, Mr. Waggener urges anyone interested in rounding out the AMA meeting with a visit to Hawaii to write for complete information to the Indiana State Medical Association, 1021 Hume Mansur Building, Indianapolis 4, Indiana, with attention directed to the executive secretary.

Blue Shield Plans 9 Seminars For M.D.s' Secretaries

Training seminars for physicians' secretaries have been scheduled by Kentucky Physicians Mutual, Inc., the Blue Shield Plan, for nine Councilor Districts of the KSMA during the remainder of 1954.

According to Ros W. Harrison, Louisville, Blue Cross and Blue Shield public service director, the complete 1953-54 program has 14 seminars scheduled—one to be held in each Councilor District except District Ten, where the seminar is sponsored by the West Virginia Blue Shield Plan.

A tentative schedule for April and May will include training sessions in Councilor Districts Seven, Nine, Thirteen and Fourteen, Mr. Harrison said.

The meetings are designed to teach the secretary how she may foster good physician-patient relationships and be of greater assistance to the public by giving her an understanding of the Blue Shield Plan and its operation.

Representation at the meetings has been excellent, according to Mr. Harrison. Physicians' secretaries, receptionists and medical assistants as well as doctors themselves are invited to attend.

Dr. Hancock to Speak at Meeting Of 1st District, April 28

J. Duffy Hancock, M.D., Louisville, president of the Kentucky State Medical Association, will speak at a meeting of the First Councilor District, to be held at the Ritz Hotel, Paducah, April 28, according to J. Vernon Pace, M.D., Paducah, district councilor.

Another speaker on the program will be D. Woolfolk Barrow. M.D., Lexington, whose topic is entitled, "Varicose Veins." McCracken County Medical Society will act as the host group, Dr. Pace said.

At Journal press time, some details of the program had not been completed, but further information will be sent to members as it is assembled, Dr. Pace indicated.

Audio-Digest to Donate Profits To AMEF Foundation

Profits from the Audio-Digest Foundation, recently formed subsidiary of the California State Medical Association, will go to the American Medical Education Foundation, it was reported in the "AMA's Secretary's Letter.

If 20,000 physicians subscribe to the new communication service for medical learning, the AMEF estimates it can reap approximately one million dollars.

The Audio-Digest Foundation recently requested and was granted scientific exhibit space at the Kentucky State Medical Association Annual Meeting, September 21, 22, and 23, at the Columbia Auditorium in Louisville.

Using tape recorded material, the Audio-Digest makes available to physicians three postgraduate services, designed to save their time while increasing the scope of their knowledge. Basic service offered is a one-hour tape issued weekly, on which are recorded from 20 to 30 abstracts selected from all fields of current medical literature.

Dr. Rankin Honored

The amphitheatre at the Louisville General Hospital has been completely renovated with seating capacity increased to 400, and has been named the Fred W. Rankin Amphitheatre. James A Kennedy, secretary of the Medical Council, who made the announcement, said Dr. Rankin has been on the surgical staff of the University of Louisville School of Medicine for over thirty years and professor of surgery since 1941.

KSMA Welcomes 18 New Members

The Kentucky State Medical Association recently welcomed eighteen new members from various sections of the state as of March 4, 1954. The new members are:

Louis J. Beto, M.D., Danville

John Boldrick, M.D., St. Joseph Hospital, Lexington;

Karl N. Boyd, M.D., Cumberland;

W. H. Cloyd, M.D., Glasgow

A. P. Dell Cost, M.D., Veterans Administration Hospital, Lexington;

George B. Edmiston, M.D., Prestonsburg

Roy A. Edwards, M.D., Hopkinsville;

Jekabs Knessknezinskis, M.D., Western State Hospital, Hopkinsville;

A. F. Miller M.D., Harlan;

M. K. Miner, M.D., Cumberland;

William C. Mitchell, M.D., Cloverport

Alfred Mitenieks, M.D., Western State Hospital, Hopkinsville;

Lawrence R. Nickell, M.D., Owingsville;

E. Puess, M.D., Tuberculosis Hospital, Glasgow;

Robert W. Rasor, M.D., U. S. Public Health Service Hospital, Lexington;

Freeman L. Rawson, M.D., Cumberland;

Alex B. Shipley, M.D., Louisville;

J. A. Stout, M.D., Grayson.

Dr. Moberly Receives Appointment

Fred P. Moberly, M.D., Lexington, was recently appointed by Lawrence W. Wetherby, governor of Kentucky, to serve as a member of the State Board of Health for a term to expire December 31, 1954. Announcement of the appointment was received from the executive chamber of the governor in Frankfort. Dr. Moberly will fill a vacancy created by the death of George S. Conn, M.D., Louisville.

Dr. Steigman Becomes Dept. Head

Alex J. Steigman, M.D., Louisville, has been selected to head the Department of Pediatrics, University of Louisville School of Medicine, effective July 1, 1954, according to J. Murray Kinsman, M.D., dean. Dr. Steigman, who has been Professor of Child Health in the Department of Pediatrics since 1950, will succeed Leonard T. Davidson, M.D., Louisville, who has headed the department for over five years.

Washington News Digest

Washington, D. C.—Just about a year ago the Hill-Burton hospital construction program was under heavy attack in the House Appropriations Committee. But the damage was not permanent. The program has made a complete recovery. More than that, Congress shows every intention of doubling the appropriation for the program, but earmarking the additional money for grants to diagnostic and treatment centers, rehabilitation facilities, hospitals for the chronically ill, and nursing homes. At this stage the legislation to stimulate health facility construction is believed to be closer to enactment than any other major health project of the Eisenhower administration. Although the main objectives have not been altered, some significant changes were made in the bill by the House Interstate and Foreign Commerce Committee in two weeks of intensive work at closed-door sessions. Then, in mid-March, the Senate committee took up the bill and considered additional amendments.

Most changes are designed to tighten up eligibility for grants. For example, money could go to only two types of diagnostic or treatment centers, those operated by and for a governmental unit or by a group that also operates a nonprofit hospital. Nor would centers or nursing homes be eligible unless under medical supervision or operated by an association that also operates a hospital.

Another change written into the bill would rule out a project if it were not to be open for full and unrestricted use by the general public. Thus labor union, fraternal, and prepayment health plans could not benefit if they offered their own subscribers any advantage in service at the center or hospital.

On the financial side, several amendments have been tentatively adopted. One would allow states to use the original Hill-Burton formula for appropriating money among projects, or to accept a flat 50% federal contribution. (As in the original Hill-Burton act, the poorer states would be allocated more per capita.) States would be allowed to pool their allocations for construction of interstate facilities, and the United States would be authorized to recover its proportionate share of a project if at any time the project were converted to profit use or were transferred to interests which for any other reason would not be eligible.

Of major interest to the medical profession, although not far along on its legislative course, is the administration's proposal for subsidizing prepaid health plans for federal civilian employees. The U. S. would pay a maximum of $26 per year, to be matched by the employee, for the purchase of any type of prepaid insurance. Any cost above $52 per year would have to be borne entirely by the employee.

As part of the program, the administration is proposing that payroll deductions be authorized, a concession the insurance and prepayment insurance organizations have been urging for years. Currently federal executives differ on whether payroll deductions would be "legal," but none is willing to risk authorizing deductions in the absence of specific approval from Congress.

Still following a slow and controversial course is the administration's proposal for reinsurance of health plans. Early in the session—with the ardent support of Chairman Charles S. Wolverton of the key House committee—this legislation appeared pointed toward enactment. However, the Department of Health, Education, and Welfare was not satisfied with Mr. Wolverton's bill and decided to draft one of its own. The drafting consumed many weeks—time that may prove fatal with a Congress hoping to adjourn early for the fall elections.

The Defense Department, made uncomfortable by a few suspected subversive physicians and dentists it doesn't quite know what to do with, is asking for an amendment to the Doctor Draft act. The department's problem is this: The most recent Court of Appeals decision holds that physicians or dentists drafted or called up from the reserves must, under the Doctor Draft act, either be commissioned or discharged. So, technically, a man who refuses to fill out his loyalty questionnaire would be rewarded by a release. To correct the situation, the Department is asking that the law be changed to allow it to withhold a commission from a loyalty suspect, yet keep him on duty for the specified time in noncommissioned status and assigned to professional duties.

The American Medical Association is continuing its support of Senator Bricker and others who are convinced they still can enact a resolution calling for an amendment to restrict international agreements. The Association's position is that unless a safeguard is written into the Constitution, future international agreements could impose on the country social and medical care programs that Congress itself would not approve.

Application

FOR SPACE IN THE SCIENTIFIC EXHIBIT

1954 Annual Meeting Kentucky State Medical Association

Columbia Auditorium Louisville, Kentucky September 21, 22, 23

Fill Out and Mail to:

EVERETT L. PIRKEY, M. D., *Chairman*
Committee on Scientific Exhibits
Louisville General Hospital,
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---

1. Title of Exhibit: .....
2. Description or nature of exhibit: (Attach brief description to this blank).
3. Will you require shelf space? .....
4. Give approximate amount of wall space needed. (Included in total space is two side walls of two feet in length) .....
5. Name of institution co-operating in the exhibit (if desired) .....
6. Name of exhibitor: .....

..... (Street & No.) ..... (City)

(Deadline for mailing application August 1, 1954)

The Kentucky State Medical Association will provide without cost to the exhibitor the following: Exhibit space, shelves, sign for booth, current, bracket lights... provided all items are approved in advance by the committee.

Cost of transporting exhibits to the meeting must be borne by the individual exhibitor as well as costs of cards, signs, etc., which are a part of the exhibit.

View boxes, furniture, decorations, etc., may be rented, if desired, by applying directly to Jos. T. Griffin Company, 704 West Main Street, Louisville 2, who supply equipment for the annual K.S.M.A. meeting.

News Items

William C. Roland, M.D., formerly of Rhode Island, has located in Pikeville for the practice of orthopedic surgery. Dr. Roland recently came to Kentucky from the U. S. Naval Hospital, Newport, Rhode Island. A 1942 graduate of the Southern California School of Medicine, he interned at the U. S. Naval Hospital, San Diego, California.

Harold Funke, M.D., formerly of Bardwell in Carlisle county, recently joined the staff of Central State Hospital, Lakeland. Born in Missouri, Dr. Funke attended the University of Louisville and was graduated in 1946. He interned at St. Elizabeth Hospital, Covington, before his service in the Medical Corps of the United States Army from 1947 to 1949. Since 1950 he has been practicing in Bardwell.

Joseph C. Bell, M.D., Louisville, will speak before the Section on Radiology at the Annual Meeting of the Ohio State Medical Association, Wednesday, April 14, on the subject "Intravenous Urography—Indications and Contraindications—Contrast Media—Reactions." On April 15, he will address a General Session on "Radiological Problems in Trauma of the Head and Neck." Dr. Bell is Professor of Roentgenology at the University of Louisville School of Medicine and Chief of the Department of Radiology, Norton Memorial Infirmary.

Theodore L. Adams, M.D., Lexington, has been appointed to serve on the Committee on Emergency Medical Service of the Kentucky State Medical Association, according to J. Duffy Hancock, M.D., president.

Bernard Schneider, M.D., Louisville, has been awarded the degree of Master of Medical Science for graduate work in Obstetrics and Gynecology at the Spring Convocation of the University Council of the University of Pennsylvania. The title of Dr. Schneider's thesis was "Cesarean Section in a Small Urban Hospital, 1944-1951."

Champ Ligon, M.D., Lexington, recently joined the staff of Eastern State Hospital, Lexington. A graduate of the University of Louisville School of Medicine in 1951, Dr. Ligon interned at St. Joseph Hospital in Lexington.

Blanton E. Russell, M.D., who received his medical degree from the University of Louisville School of Medicine in 1930 and is now manager of the Veterans Administration Hospital at Beckley, West Virginia, has been named to manage the new 496 bed general medical and surgical hospital at Cincinnati.

Walter L. O'Nan, M.D., Henderson, chairman of the KSMA Rural Health Council, addressed the Woman's Auxiliary to the Fayette County Medical Society on February 16, in Lexington. He spoke on "Rural Health."

Pertinent Paragraphs

George Bugbee, for the past 11 years executive director of the American Hospital Association, Chicago, has recently been appointed president of Health Information Foundation, an organization which represents 5,200 hospitals of the nation. Mr. Bugbee will assume his new post about May 1st.

The World Medical Association, representing 700,000 physicians of 46 national medical societies, recently announced that it plans to establish an International Committee on Occupational Health for the benefit of all industrial workers. According to Louis H. Bauer, M.D., New York, secretary-general, the WMA and the Council on Industrial Health of the AMA will sponsor an International Conference on Occupational Health in 1957.

Howard P. Doub, M.D., head of the department of radiology, Henry Ford Hospital, Detroit, Michigan, was recently elected the 31st president of the American College of Radiology during the annual meeting in Chicago. Dr. Doub, well-known for his contributions to the medical specialty of radiology, is past president of the Radiological Society of North America and editor of the society's scientific publication.

Frank E. Wilson, M.D., director of the AMA Washington office, was one of four physicians recently promoted to Brigadier General, Medical Corps, United States Army Reserve. During World War II he spent two years overseas in the Army Medical Corps, completing his service with the rank of Colonel.

BOOK REVIEWS

CURE YOUR NERVES YOURSELF, by Louis E. Bisch, M.D., Ph.D., Wilfred Funk, Inc., New York, 1953, Cloth, pp 246, $3.50.

Here is another addition to the great flood of "Do It Yourself" books now inundating the country. One may seriously question the advisability of such efforts in the field of psychiatry. In carpentry, for example, the inept pupil may end up with no more than some ruined lumber, whereas in psychiatry, the pupil may end up worse than inept.

The volume is obviously designed for popular consumption, but even so, it is over-simplified and too full of dogmatic statements. To say that "Truly great men and women are not eccentric," is to imply new definitions of the words being used.

Similarly, "When a woman gives birth to a baby she is able to stand the ordeal because of normal masochistic tendencies," seems to be an unnecessary fancying-up of a pretty well established process. As for " . . . . anybody can become mature if he will but take himself in hand . . . ." is well calculated to increase guilt feelings.

One also finds contradictory counsel, such as, "You cannot afford to reveal your emotions," versus "Rule Number One: Be sure you do not repress your emotions." This should pose a neat problem to the distressed reader. Specific points as these may be found throughout the book, but enough of them.

In general, the book is optimistic to an extreme and constitutes only another obeisance to the fashion of wanting everything the quick and easy way. One feels the author has not answered his introductory question, "Why Another Book on Nerves?"

Jack L. Chumley, M.D.
Louisville

SCHOOL HEALTH SERVICES: A Report of the Joint Committee on Health Problems in Education of the National Education Association and the American Medical Association with the cooperation of contributors and consultants. Edited by Charles C. Wilson, M.D., National Education Association and American Medical Association. Cloth, pp 486, $5.00.

This report is a comprehensive survey and reference work which should be of considerable help to anyone, medical or non-medical, who is interested in this field. It contains many useful tables, a number of examples of standard forms and several attractive illustrations. In the appendices are imposing lists of contributors and consultants.

As a matter of fact, the book is so well gotten-up and contains such a wealth of information that it will probably prove useful to many who are neither educators nor school physicians.

Jack L. Chumley, M.D.
Louisville

In Memoriam

EDWARD A. MORGAN, M.D.

Louisville

1882 - 1954

Dr. Edward A. Morgan, 71, Louisville, died March 1, 1954, at the Kentucky Baptist Hospital, Louisville, where he had been a patient since November, 1953. A native of Burkesville, Dr. Morgan was a psychiatrist with the Veterans Administration regional office.

He was a member of Crescent Hill Masonic Lodge and the Crescent Hill Baptist Church. Dr. Morgan was a member of the following professional organizations: Jefferson County Medical Society, Kentucky State Medical Association, and the American Medical Association.

He was a 1917 graduate of the University of Oklahoma School of Medicine.

EDWARD EVERETTE EDWARDS

Irvine

1883 - 1954

Dr. Edward E. Edwards, 69, of Irvine, died February 23, 1954, at the Pattie A. Clay Hospital, Richmond, after an extended illness.

A 1907 graduate of the Hospital College of Medicine, Louisville, Dr. Edwards was well known to the residents of Estill and Madison counties where he practiced for many years.

Early in his career, Dr. Edwards served his home and surrounding territory not only as a physician, but also as surgeon, nurse, dentist and anesthetist. Often, the hardy general practitioner was seen riding his horse over a mountain or up a creek bed in order to see his patients. Frequently, he received payment in livestock or farm produce.

Dr. Edwards was a member of the Estill County Medical Society and the Kentucky State Medical Association.



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County Society Reports

CALLOWAY

The monthly meeting of the Calloway County Medical Society was held in the chapel of the Murray Hospital, February 2, 1954, with C. C. Lowry, M.D., presiding.

Hugh Houston, M.D., Murray, reported that Morris Weiss, M.D., Louisville, president of the Kentucky Heart Association, would be in Murray, February 11, and would be available to any physician desiring consultation.

Karl E. Warming, administrator, reported that the Blue Cross and Blue Shield Drive was being accepted favorably as a whole.

The following physicians were present at the meeting: A. D. Butterworth, Charles Clark, Robert Hahs, J. L. Hopson, J. C. Hart, Hugh Houston, all of Murray; C. H. Jones, Lynn Grove; and C. C. Lowry, O. K. Mason, R. M. Mason, J. A. Outland, John C. Quertermous, Kenneth Ross, Charles Tuttle, all of Murray.

J. L. Hopson, M.D., Secretary

HOPKINS

The monthly dinner meeting of the Hopkins County Medical Society was held at the Hopkins County Hospital, Madisonville, January 29, 1954, with M. M. Mahr, M.D., presiding. Seventeen physicians attended.

An announcement of the increase in Kentucky State Medical Association and American Medical Association dues was made.

F. A. Scott, M.D., was elected to represent the society at the Hopkins County Hospital Board of Directors. A. F. Finley, M.D., was selected alternate delegate.

R. J. Dancey, M.D., of Madisonville District One State Tuberculosis Hospital, presented a summary of statistics on the treatment of tuberculosis in Kentucky. Following his discussion, a series of X-rays on pulmonary pathology were shown with a brief summarization of the diagnostic problems involved.

M. C. Arnold, M.D., Secretary

MASON

The annual election of officers was held at the last monthly meeting of the Mason County Medical Society, February 4, 1954, with W. H. Cartmell, M.D., presiding.

Harry C. Denham, M.D., was elected the new president; William H. Sewell, M.D., secretary-treasurer; William H. Cartmell, M.D., delegate to the Kentucky State Medical Association, and Joseph E. McKinney, M.D., alternate delegate.

At the business session, nutritional deficiencies found in county school children which had been uncovered by the Public Health Department Clinics held by members of the society, were discussed.

The society decided to invite Miss Betty Soughers, nutritionist in the Health Department, to discuss these deficiencies and offer suggestions as to their corrections.

When membership dues were discussed, the society recommended that the treasurer contact all members immediately and collect the dues for the county, state and AMA.

Dr. Cartmell reviewed some of the projects completed and accomplishments of the society during the last year.

The following physicians were present: C. G. Prindle, H. C. Denham, M. B. Denham, C. W. Christine, J. E. McKinney, and W. H. Cartmell. W. H. Sewell, M.D., was voted to membership in the society.

William H. Sewell, M.D., Secretary-Treasurer

McCRACKEN

The monthly dinner meeting of the McCracken County Medical Society was called to order February 24, 1954, with R. W. Robertson, M.D., presiding in the absence of Keith Sloan, M.D., president, and Goodloe Sargent, M.D., vice-president.

After some explanation, it was moved that the society go on record as opposing Bill 290 in the State Legislature. The motion carried.

Eugene Blake, M.D., reporting for the Library Committee, discussed addition of new books and journals in remodeling the library. It was moved that the society give the committee authority to dispose of old volumes and acquire new ones as needed. The motion carried.

William B. Haley, M.D., discussed a new approach to solving present problems in the local Red Cross Blood Bank. It was moved that Dr. Haley and his committee be empowered to carry out the program as he had outlined or any other agreement that he sees fit to improve the drawing of blood. The motion carried.

Dr. Blake moved that the society go on record as favoring a refresher course for Licensed

(Continued on page 296)

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THE PROBLEM OF FOREIGN-TRAINED PHYSICIANS

(Continued from page 275)

preliminary report of a seven-year survey based on a division of the country into 757 trading areas.

Dr. Dickinson reported that every town with a population of more than 5,000 had at least one physician in active practice, as had 96 per cent of those with a population between 2,500 and 5,000; 88.3 per cent of those with a population of between 1,000 and 2,500, and 21 per cent of those with a population between 100 and 1,000. More than half of the latter group had less than 250 inhabitants. Only one-sixth of one per cent of the population lived outside a 25-mile radius of the closest town with a physician in active practice, he said.

State medical practice acts show a wide variance, it was reported by George E. Hall, Chicago, staff associate of the A.M.A.'s Bureau of Legal Medicine and Legislation. Differences exist, Mr. Hall said, in such matters as the method of appointment of licensing boards, the membership of such agencies, the type of examinations, the requirements of professional skill, the reasons for revoking of licenses, the exemptions from the acts, and reciprocity.

"Lack of uniformity in the medical practice acts is nothing new," he pointed out. "Few people realize the extent because these laws have been so ably administered that a large measure of practical uniformity has actually been achieved."

Nevertheless, he urged, efforts should be made to obtain uniformity in the laws.

A committee headed by Dr. Bruce Underwood, Louisville, secretary of the Kentucky State Board of Health, suggested that a uniform Medical Practice Act be developed and be submitted next year.

Dr. George W. Covey, Lincoln, Neb., a former member of the Nebraska Board of Medical Examiners, reviewed recent developments involving a possible recognition of osteopathy and concluded that the practice was still a cult.

Dr. John C. Leonard, Hartford, Conn., director of medical education at the Hartford Hospital, said nonuniversity hospitals must be kept abreast of medical developments. Dr. Leonard urged the maintenance of a sound program of graduate training.

A new test technique to make the oral or practical licensure examination more objective and more easily analyzed was recommended by John T. Cowles, Ph.D., Princeton, N. J., of the Educational Testing Service. Dr. Cowles said effort has been focused almost exclusively upon the improvement of the written examination, to the detriment of the oral and practical tests.

COUNTY SOCIETY REPORTS

(Continued from page 294)

Practical Nurses and that a letter be sent to Dr. Scully informing him of this action.

It was moved that William H. Smith, M.D., and Samuel L. French, M.D., be admitted to the McCracken County Medical Society by transfer. The motion carried. A letter of application from R. T. Brooks, M.D., was read and referred to the Board of Censors.

On the scientific program, Charles Wood, M.D., associate professor of orthopedics, University of Louisville School of Medicine, discussed "The Management of Fractures in Children."

M. W. Fowler, M.D., Secretary

SHELBY-OLDHAM

The Shelby-Oldham County Medical Society met February 25, 1954, at the Old Stone Inn, near Shelbyville. L. A. Wahle, M.D., Shelbyville, presided over the business session following the dinner.

Herbert Clay, M.D., Louisville, guest speaker, gave a scientific discussion on "The Management of Hypertension." He was introduced by H. H. Richeson, M.D., Louisville.

The following members and guests were present: Charles Chatham, D.D.S., Don Chatham, M.D., Shelbyville; Herbert Clay, M.D., Louisville; A. D. Doak, M.D., Shelbyville; J. F. Furnish, M.D., Taylorsville; H. A. Heise, D.D.S., M. D. Klein, M.D., Shelbyville; E. G. McMunn, M.D., Shelbyville;

H. B. Mack, M.D., Pee Wee Valley; S. B. May, M.D., Eminence; Wyatt Norvell, M.D., New Castle; George Ray, M.D., Louisville; H. H. Richeson, M.D., Louisville; C. C. Risk, D.D.S., Shepherdsville; B. B. Sleadd, M.D., Middletown; M. H. Skaggs, M.D., Taylorsville; S. B. Sternberg, M.D., Shelbyville; L. A. Wahle, M.D., Shelbyville, and A. C. Weakley, M.D., Shelbyville.

C. C. Risk, D.D.S., Secretary



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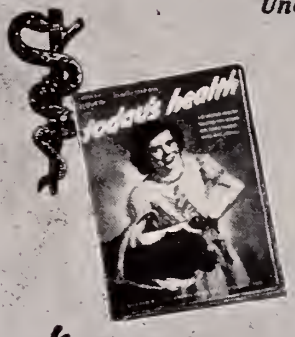
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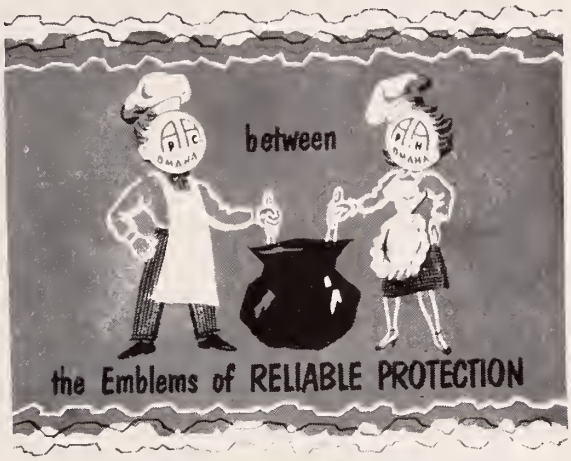
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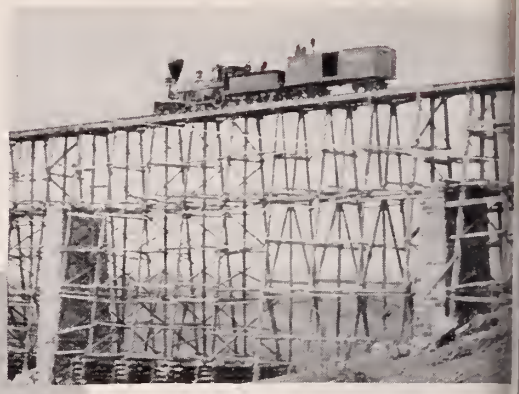
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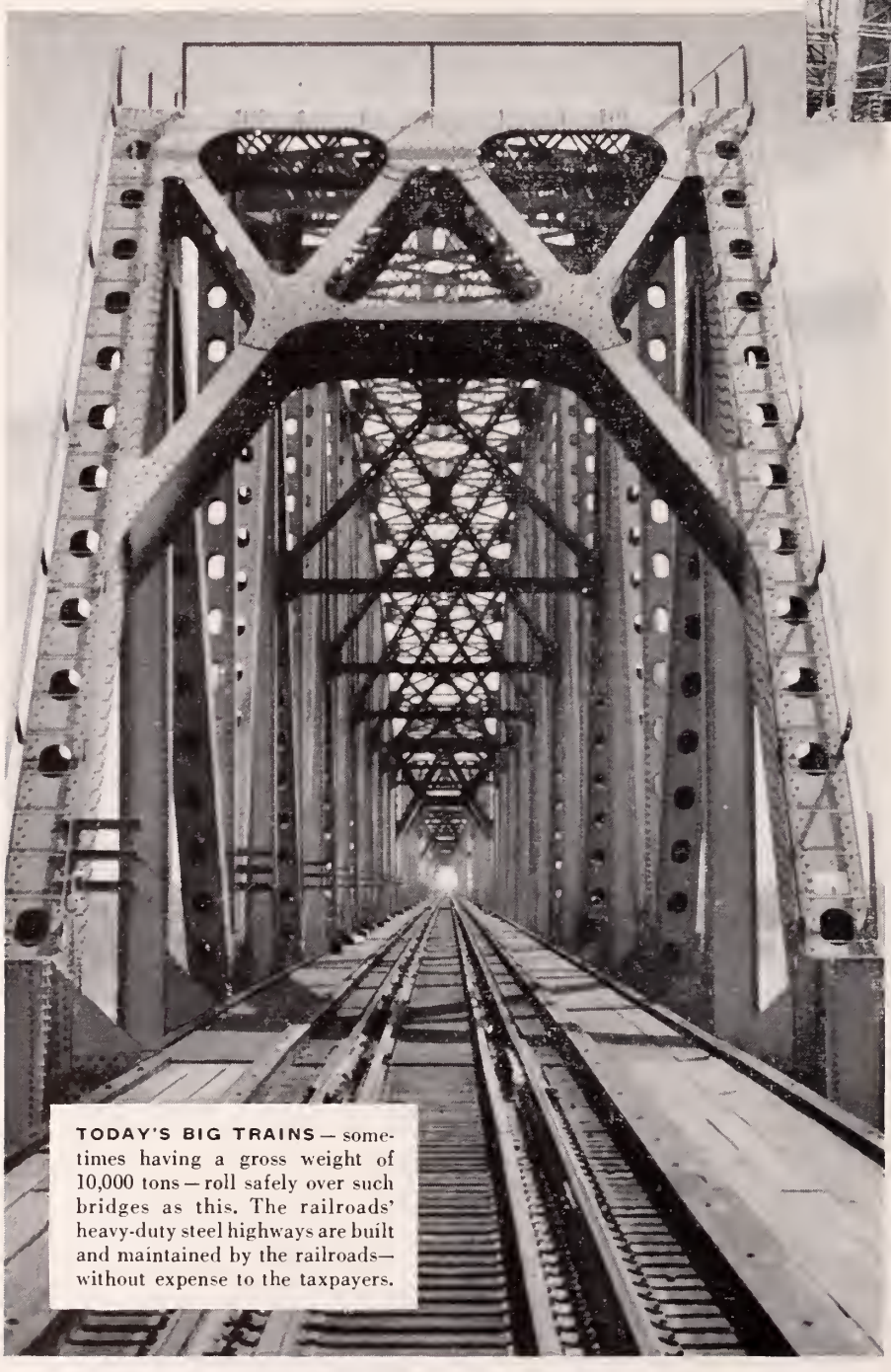
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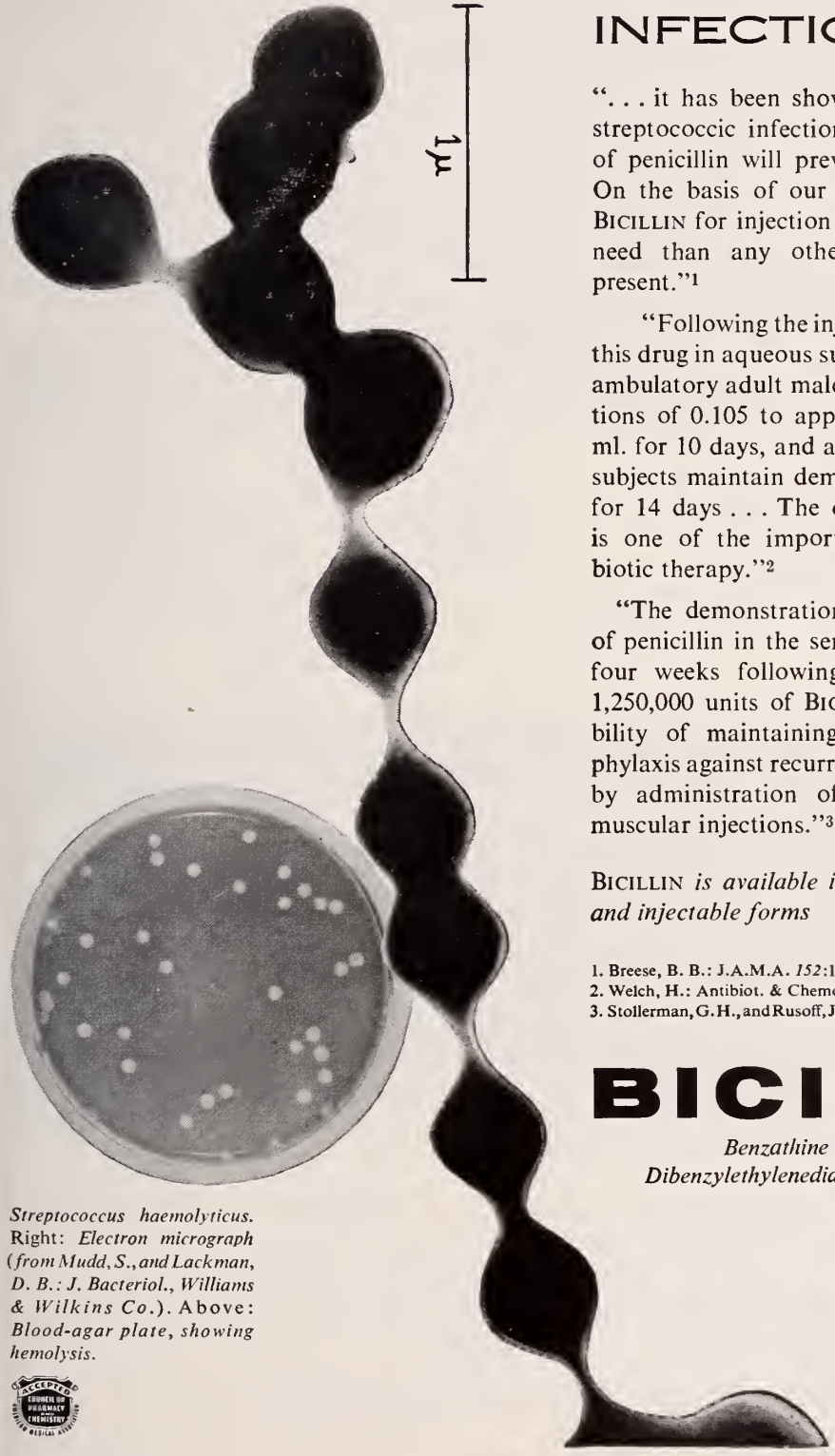
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1. Breese, B. B.: J.A.M.A. *152*:10 (May 2) 1953
2. Welch, H.: Antibiot. & Chemo. *3*:347 (April) 1953
3. Stollerman, G. H., and Rusoff, J. H.: J.A.M.A. *150*:1571 (Dec. 20) 1952

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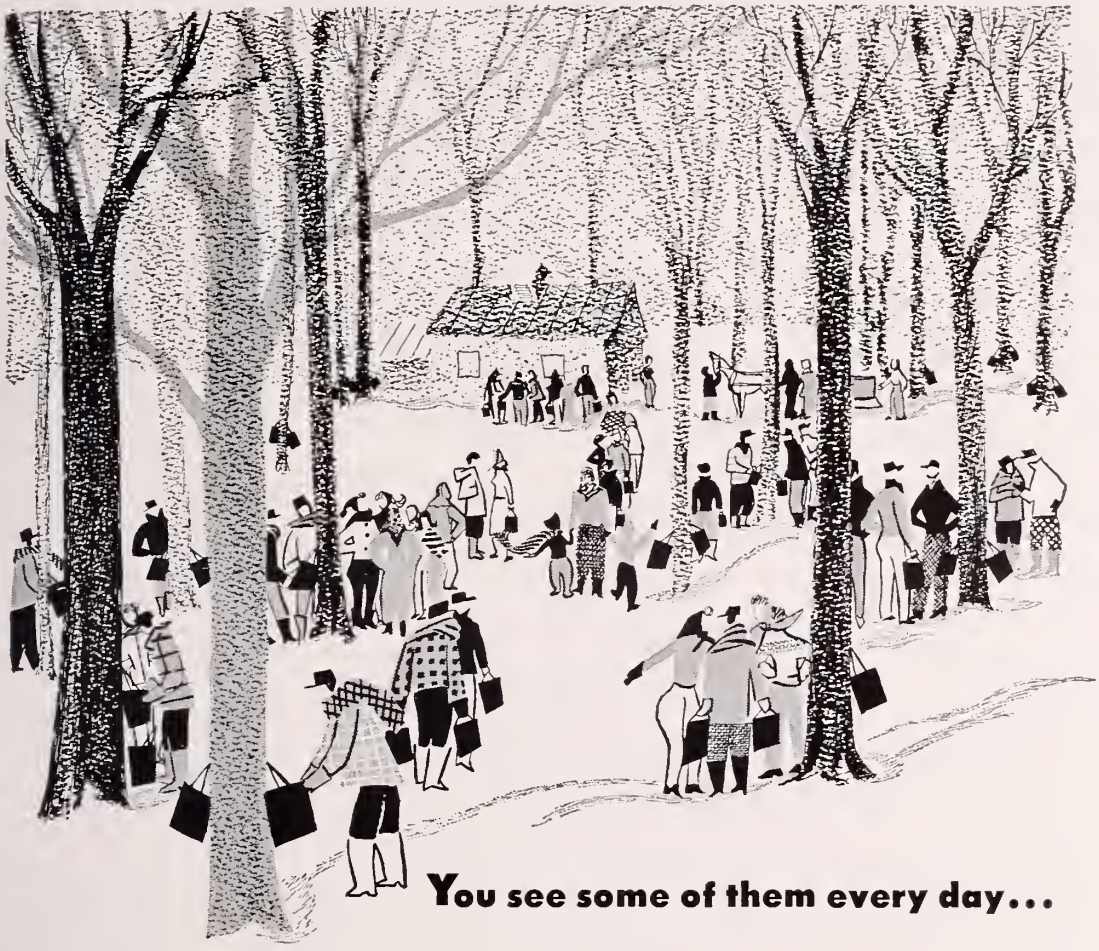
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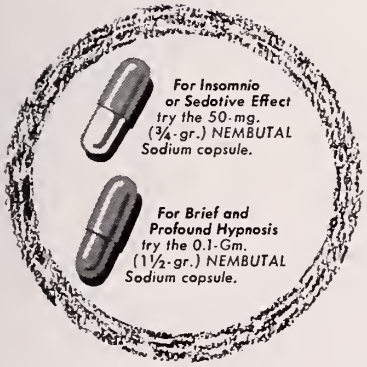
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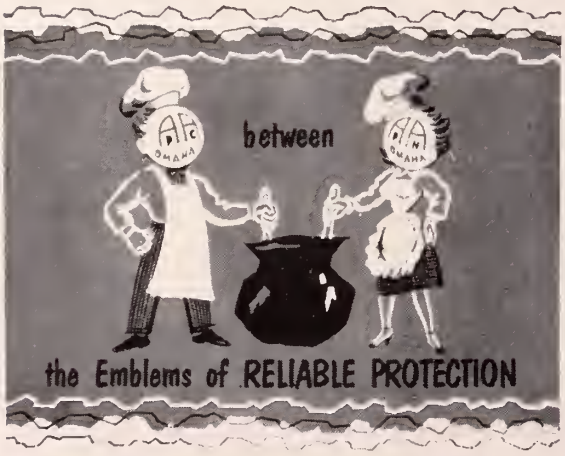
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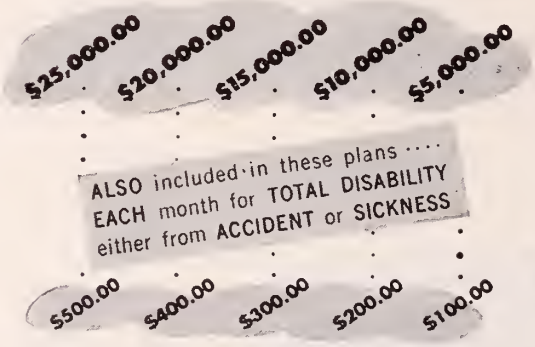
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**English, A. R., et al.: Antibiotics Annual (1953-1954), New York, Medical Encyclopedia, Inc., 1953, p. 70.*

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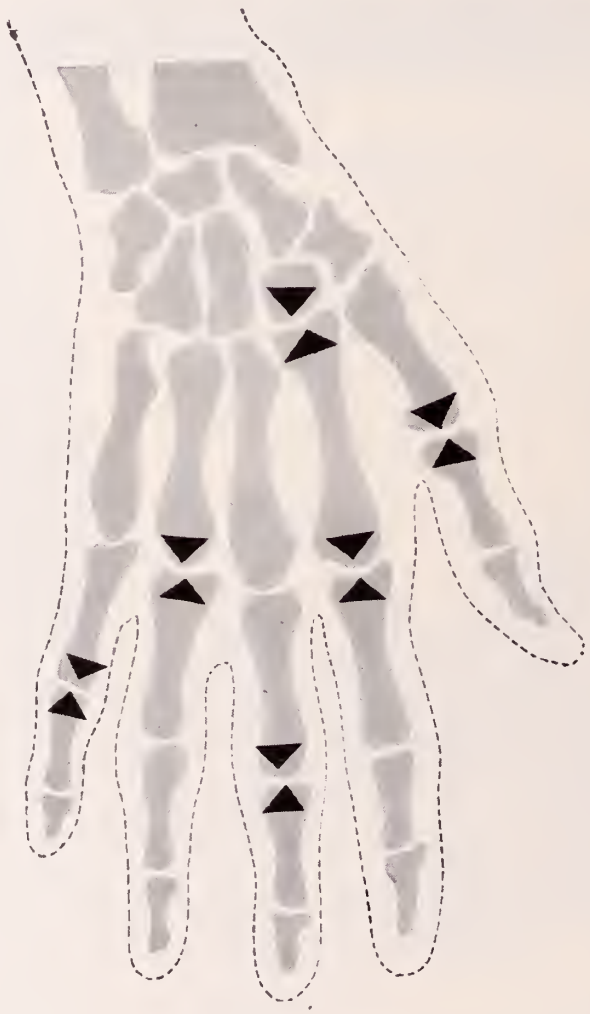
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1. Werner, A.: Acta endocrinol. *13*:87, 1953.
2. Malleson, J.: Lancet *2*:158 (July 25) 1953.
3. Goldzieher, M. A., and Goldzieher, J. W.: Endocrine Treatment in General Practice, New York, Springer Publishing Company, Inc., 1953, p. 23.

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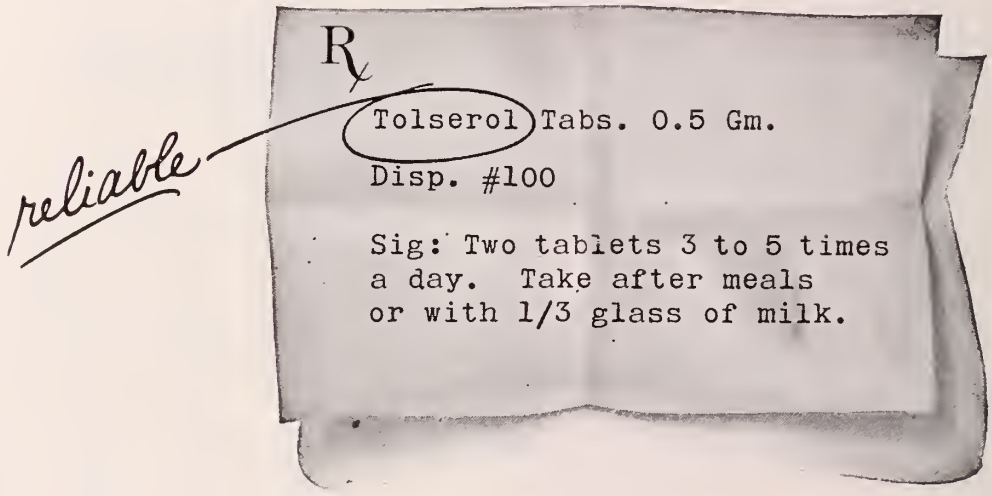
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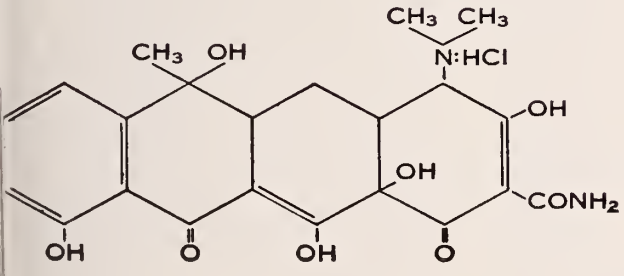
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From a practical dietary standpoint, meats-in-a-can—preserved by commercial canning—are nutritionally interchangeable with meats of like variety prepared in the home.[1] For taste appeal, for economy and "keeping" quality, and for household convenience, meats-in-a-can are advantageous in many respects.

As the comparative data here shown indicate, kitchen-prepared meats and similar meats-in-a-can are closely alike in the amounts of various nutrients they provide.

COMPARATIVE COMPOSITION OF KITCHEN-COOKED AND COMMERCIAL-CANNED MEATS
(Nutrient Amounts per 100 Grams)

	*Kitchen-Cooked Ham[2]	**Canned Ham[3] (Chopped, Cured)	Kitchen-Cooked Beef Round[2]	Canned Roast Beef[2]
Water	50%	50%	59%	60%
Protein	21 Gm.	20 Gm.	27 Gm.	25 Gm.
Fat (ether extract)	28 Gm.	20 Gm.	13 Gm.	13 Gm.
Niacin	4.0 mg.	4.3 mg.	5.5 mg.	4.2 mg.
Riboflavin	0.21 mg.	0.19 mg.	0.22 mg.	0.23 mg.
Thiamine	0.46 mg.	0.40 mg.	0.08 mg.	0.02 mg.

*Values after conversion from 42% to 50% water basis.
**Values after conversion from 58.69% to 50% water basis.

Experimental studies have shown that the processing which meats-in-a-can undergo leads to little if any greater vitamin losses than does home-cooking of similar cuts of meat. In general, meats-in-a-can retain of their original vitamin content approximately:

60 to 80 per cent of thiamine
90 to 100 per cent of riboflavin
90 to 100 per cent of niacin
80 per cent of biotin
70 to 80 per cent of pantothenic acid.[4,5]

During storage for customary periods, at usual warehouse temperatures, meats-in-a-can show little, if any, further vitamin loss except in thiamine. Even thiamine, a highly thermolabile vitamin, was 52 per cent retained in pork-in-a-can after ten months' storage at 80° F. Retention of the vitamin was notably greater when the canned pork was stored at 38° F.

Since meats-in-a-can are thoroughly cooked in processing, they may be consumed as purchased, merely warmed or mildly cooked. When the meat is moderately cooked in preparation for consumption, little or no further loss in vitamins need to occur.

Recent studies show that meats-in-a-can are excellent sources of needed amino acids.[6] The 18 amino acids determined in these studies appeared in similar ratio and amounts in canned beef, pork, and lamb as in the respective fresh or home-cooked meats.

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The Seal of Acceptance denotes that the nutritional statements made in this advertisement are acceptable to the Council on Foods and Nutrition of the American Medical Association.

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8 Cardiac work is not increased, tachycardia is not engendered.

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The Clinical Selection of Patients with Surgical Congenital Heart Disease

HAROLD D. ROSENBAUM, M.D.
Lexington

It is well known that giant strides have been made in the surgical treatment of congenital heart disease. At present, probably 60% of all patients with cardiac anomalies who survive infancy have lesions which may be treated surgically. When one considers that it has been claimed by some that about 2% of all heart disease is congenital in etiology it is apparent that operable congenital heart disease constitutes a very significant group of patients.

It is obviously very important for all practicing physicians to be able to select from the entire group of patients with congenital heart disease those whose anomalies are amenable to surgery so that these individuals may be referred to specialists who can determine the feasibility of operation in the particular situation being considered. Unfortunately, many of the complex procedures currently being used to make exact anatomical diagnoses require special training and experience. Nevertheless, selection of surgical cases of congenital heart disease can be made in most instances by use of nothing more than a careful history and physical examination, an electrocardiogram with chest leads and an x-ray examination with fluoroscopy.

Cyanotic Congenital Heart Disease

To most people the "blue baby" epitomizes congenital heart disease. Certainly, many of the patients with malformations that lead to cyanosis are dramatically improved after surgery.

Since all of the operative procedures performed for these conditions are designed to increase the amount of blood flowing to the lungs, it is obvious that a determination of the amount of pulmonary blood flow is all that is necessary to decide whether there is a chance for a cyanotic patient to be helped by surgery. Every cyanotic patient whose anomaly produces pulmonary oligemia is a possible candidate for surgery and should be studied by qualified specialists with such in mind. On the other hand, no surgery exists at present for cyanotic patients with an adequate flow of blood to the lungs.

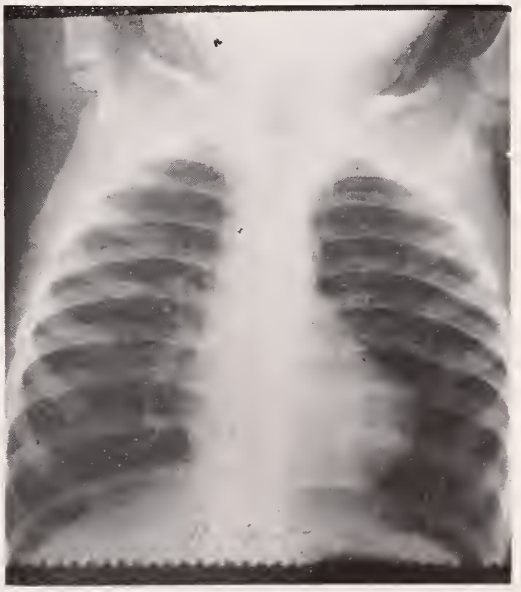


Figure 1. Tetralogy of Fallot in a 5 year old male. Note elevated apex and lack of cardiomegaly as well as diminution in the pulmonary vascular markings.

Read before the Fayette County Medical Society, December, 8, 1953.

The amount of blood flowing to the lungs is primarily determined by the x-ray examination, although a markedly diminished and/or very short pulmonic second sound in a cyanotic patient suggests reduction or absence of the pulmonary valvular component of this sound and, secondarily, the presence of pulmonary oligemia. The chest film of a patient with decreased pulmonary blood flow classically shows a marked diminution in the size and number of the vascular markings, especially in the lung fields that lie well outside the hila (Figure 1).

Frequently, collateral vessels to the lungs develop from the bronchial arteries. In these cases the number of blood vessels seen on a chest film appears adequate or even abundant. On casual observation, the lungs seem to be well supplied with blood, as is the situation with cases of inoperable cyanotic congenital heart disease; however, patients with collateral pulmonary circulation fail to show the normal regular decrease in the size of the vessels as they proceed outwardly from the hilum (Figure 2). Collateral vessels are relatively the same size in all portions of the lungs and appear on the chest film as numerous punctate spots of increased density.

Since about 70% of cyanotic patients who survive infancy are those with the tetralogy of Fallot, most of the individuals who come to surgery will suffer from this entity; however, some patients with tricuspid atresia, and a rare patient with other anomalies, may be helped by surgical intervention. If possible, surgery should be delayed to about the age of four years, since mortality figures are very high for operations upon younger patients. Patients operated upon after the age of 20-30 years usually are not greatly benefitted[1].

Acyanotic Congenital Heart Disease

When cyanosis is absent a somewhat more accurate diagnosis must be made to determine operability. Valuable surgical procedures are currently available for coarctation of the aorta, patent ductus arteriosus, isolated pulmonic valvular stenosis, atrial septal defect and some anomalies of the great vessels. A diagnosis of these conditions can be made in the vast

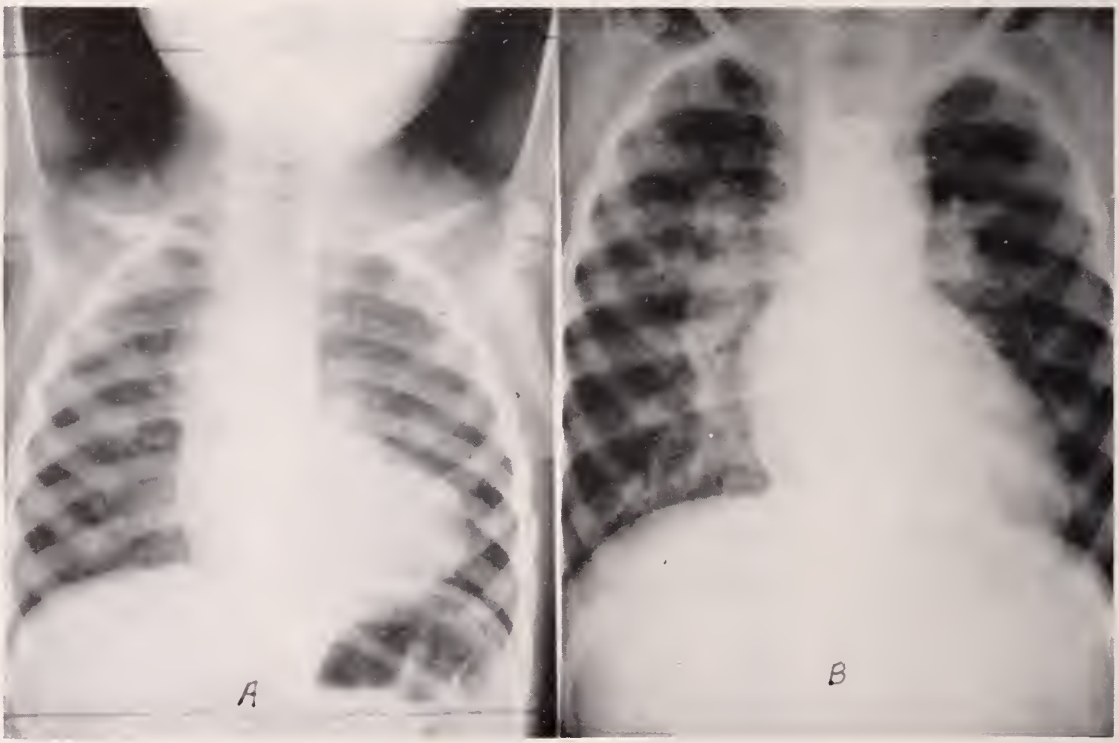


Figure 2. (A) Tetralogy of Fallot with collateral circulation in a 4 year old female. (B) Transposition of the great vessels in a 6 year old male. Note the punctate appearance of the vascular markings in (A) as well as absence of the large hilar shadows seen in (B). A right aortic arch, present in about 20% of cases of the tetralogy of Fallot, is seen in Case A, which also shows the typical "wooden shoe" contour of the cardiac shadow.

majority of instances by use of readily available diagnostic procedures.

Coarctation of the Aorta

A lower blood pressure in the legs than in the arms is almost pathognomonic of coarctation. Cuff determinations in both the upper and lower extremities must be made in every instance since absolute hypertension in the arms is not always present. Femoral pulses may also be present, although reduced in volume. X-ray demonstration of rib notching is equally diagnostic, but is seldom seen before twelve years of age. The roentgen "E-sign" is also valuable when present. There are of course, other clinical manifestations of this anomaly, but they are not distinctive in themselves and are not necessary to make the diagnosis.

Surgical correction is indicated for any coarctation that produces symptoms or blood pressure changes. Operation should be delayed, if possible, until an age of at least 10 years to decrease the possibility of "out-growing" the anastomosis. Surgery after the age of 35-40 years is difficult due to arteriosclerotic changes[2].

Patent Ductus Arteriosus

About 95% of patients with a patent ductus arteriosus have a "machinery," or Gibson's murmur, best heard in the 2nd left interspace near the sternum. This murmur is very distinctive and is characterized by a systolic component which is crescendic to the second sound, immediately followed by a decrescendic diastolic component. Most infants, and a few adults, will show only a systolic murmur[3], but even here careful auscultation will reveal a crescendic quality to the murmur. Widening of the pulse pressure is extremely common in this condition. Since operative treatment is curative, any patient with acyanotic congenital heart disease, a murmur loudest in the 2nd left interspace, a loud pulmonic second sound and a widened pulse pressure must be considered to have a patent ductus arteriosus until proved otherwise.

Operation is indicated for all patients with a patent ductus arteriosus, except asymptomatic cases beyond 35-40 years of age. For optimal results surgery should be delayed, if possible, until an age of at least four years[4]. Right ventricular hypertrophy or cyanosis, both indicating a complicated anomaly, are usually contraindications for surgery in both patent ductus arteriosus and coarctation of the aorta.

Isolated Pulmonic Valvular Stenosis

All patients with moderate to severe isolated pulmonic valvular stenosis with an intact ventricular septum have a loud, harsh systolic murmur, with maximal intensity in mid-systole, best heard along the left sternal border and usually loudest in the 2nd interspace. Usually there is an associated thrill. The pulmonic second sound is frequently absent. If present, it is always narrow and usually diminished in intensity. Striking right ventricular hypertrophy is shown by electrocardiography, and the chest film reveals a definite decrease in the peripheral pulmonary vascular markings.

Surgery is probably not indicated in mild pulmonic stenosis which may fail to show all of the foregoing clinical features. These findings, however, are nearly always present in moderate to marked pulmonic stenosis, in which cases surgery is of great value[5].

If the orifice of the pulmonic valve is sufficiently stenosed, cyanosis may supervene, due to increased pressure in the right atrium forcing open the foramen ovale, permitting a right-to-left shunt. In such a case, pulmonic stenosis becomes a type of cyanotic congenital heart disease. Under these circumstances, pulmonary oligemia is again the indication for surgical consideration, as it is with all other anomalies that lead to cyanosis.

Atrial Septal Defect

Surgical repair of atrial defects is now being carried out in a few centers[6], but until more experience has been obtained it seems advisable for surgical intervention to be restricted to defects of considerable size.

Although small defects may offer difficulty in diagnosis, the vast majority of sizeable lesions produce a fairly characteristic picture. Patients with a large atrial septal defect give a history of chronic passive congestion. Murmurs are less striking than with the anomalies already discussed. Usually however, there is a systolic murmur of moderate intensity, best heard along the upper left sternal border. The pulmonic second sound is almost always accentuated and well split. In contrast to pulmonic stenosis, thrills are distinctly uncommon. 95% of patients with an atrial septal defect show some de-

gree of right bundle branch block[7]; consequently, the diagnosis should be made with great reluctance in the absence of this electrocardiographic finding. There is usually an associated right ventricular hypertrophy. Cardiomegaly and striking pulmonary vascular engorgement are almost invariably seen on the chest film.

Anomalies of the Great Vessels

A double aortic arch, an aberrant right subclavian artery and a misplaced innominate artery are the three most common anomalies which may produce symptoms due to compression of the trachea and/or esophagus. Since a diagnosis of these malformations can be made only by x-ray the presence of unexplained stridor or dysphagia is an urgent indication for a fluoroscopic examination with a barium swallow.

Surgery results in a complete symptomatic cure and is indicated as soon as the diagnosis is made since most of the deaths from these conditions are due to severe aspiration pneumonitis resulting from operative intervention being too long delayed[8].

Conclusions

It is recognized that a few cases of congenital heart disease present atypical findings and require specialized examinations before a diagnosis can be made. Nevertheless, the vast majority of individuals who suffer from operable anomalies will be recognized, and may be referred for surgical consideration, if the examining physician makes a full use of the methods of study at hand.

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The Moral Philosophy of Super Radical Operations and Total Adrenalectomy in the Treatment of Breast Cancer

GEORGE BENTON SANDERS, M.D.*

Louisville

Introduction

The Halsted operation for breast cancer has been thoroughly evaluated in the world's great clinics for the past fifty years. The statistical results of this evaluation are remarkably uniform[1], and are well known to all (Figure 1).

It is beginning to appear that, while the operation is admirably suited to deal with stage I lesions, it is, unhappily, inadequate to eradicate cancer in more advanced stages. It can be shown that 45 to 60 per cent of stage II cancers have escaped the surgical field of the Halsted operation to the supraclavicular or internal mammary regions, or beyond. Saphir and Amromin[2] have shown that about 30 per cent of negative axillas in stage I lesions can, by careful scrutiny of serial lymph node sections, be found to contain cancer, thus adding to the number of occult stage II cases. Andreassen and Dahl-Iversen[3] have likewise shown that about 33 per cent of breast cancer cases with positive axillas have, in addition, cancer in the supraclavicular lymph nodes, thus increasing the number of occult stage III lesions. Since a classical Halsted radical mastectomy is adequate for complete surgical extirpation of cancer in slightly more than 80 per cent of stage I lesions solely, and since it is inadequate in all stage III and probably in more than 65 per cent of so-called stage II lesions, it can be seen at once that the most pressing problem in the surgical attack on breast cancer involves the cases in stages II and III (Figure 2).

We are coming to realize that different breast cancers have different biological characteristics. Some are lethal and kill quickly, some are sub-lethal and kill slowly, if at all, and there are countless gradations between the extremes. Unfortu-

Presented before the McCracken County Medical Society, October, 1953.

*From the Department of Surgery, University of Louisville School of Medicine, Louisville, Ky.

REPORTED FIVE-YEAR SURVIVAL RATES FOLLOWING RADICAL MASTECTOMY FOR CARCINOMA OF THE BREAST

Investigator	Stage I Per Cent	Stage II Per Cent
Marshall, Lahey Clinic[8]	75.0	37.0
Adair, Memorial Hospital[9]	82.2	43.5
Haagensen, Presbyterian Hospital[10]	71.8	37.8
Harrington, Mayo Clinic[11]	75.8	30.5
Taylor, Massachusetts General Hospital[12]	78.0	34.0
Brooks, Vanderbilt Hospital[13]	91.6	26.7
Richards, Toronto[14]	81.0	43.0
Fowler, Melbourne[15]	90.0	45.3
Berven, Stockholm[16]	72.0	38.0
Windeyer, London[17]	62.7	34.7
Cade, London[18]	87.0	35.0
Englestad, Oslo[19]	83.3	52.8

Figure 1. The Curability of Breast Cancer by Radical Mastectomy (after Bradshaw and Deaton 1) Reproduced by permission of the authors and the publishers of Southern Medical Journal.

nately, we can only learn of these characteristics as the dreary cycle of events unfolds in the individual case. If knowledge were sufficient, we should withhold radical, mutilating and disabling operations from patients with cancers of the virulent type whom we can but rarely arrest or cure, and offer effective, radical treatment only to those patients with lesions of slight or median virulence that are not too far advanced. Such, indeed, is the essence of the McWhirter philosophy of simple mastectomy plus intensive post-operative roentgen therapy for all operable cases of breast cancer[4]. Theoretically, it will cure the curable, benefit those capable of physical retardation of cancer progress, and will not harm, too much, those whom it cannot help. Time and statistical studies will tell the truth about the actual achievements of this surgical philosophy. It must be said in all fairness, however, that, to date, the results published by McWhirter approximate the over-all results achieved in stage I, II, and III cases taken collectively.

Haagensen[5], in this country, by a stricter selection of cases for radical operation, and by further refining the surgical technique of the Halsted operation into what he calls an "Ultra-Radical" mastectomy, has improved the five year survival results in stage I and stage II cases by roughly 10 per cent over generally accepted figures[6]. It can be argued that this improvement comes, not so much from technical advances in the more complete operative removal of cancer, but from a more stringent selection of cases which tends to include border-line cancers and lesions of questionable lethality, along with a greater number of very early cancers, while excluding a considerable number of more advanced cases of doubtful curability.

The observation that early cases of mammary cancer, apparently limited to the breast, are often actually incurable by the most radical mastectomy, due to cancer spread beyond the field of resection, has stimulated many to widen the scope of the surgical attack to include hitherto unreachable deposits of cancer in the supraclavicular, mediastinal, and internal mammary nodes. As Wangensteen[7] has said, "The surgeon pursuing cancer feels much like a hunting dog must feel when he is chasing a pheasant and the pheasant flies over a fence. The surgeon has the alternative, of course, of taking the fence down."

Following this philosophy, Wangensteen[8] proposes a "super-radical" operation done through two incisions, resecting breast, pectoral muscles, axillary content, supraclavicular contents, mediastinal fat, nodes, and areolar tissue; the thymus, and both internal mammary chains in one block for all clinically proven stage II lesions. This tremendous operation physically encompasses all known anatomical areas to which mammary cancer first makes its escape from its primary source in the breast. Valid objections to the routine employment of this procedure in stage II cases are, however, that the mortality and morbidity are high, and that the effectiveness of the procedure in extirpating

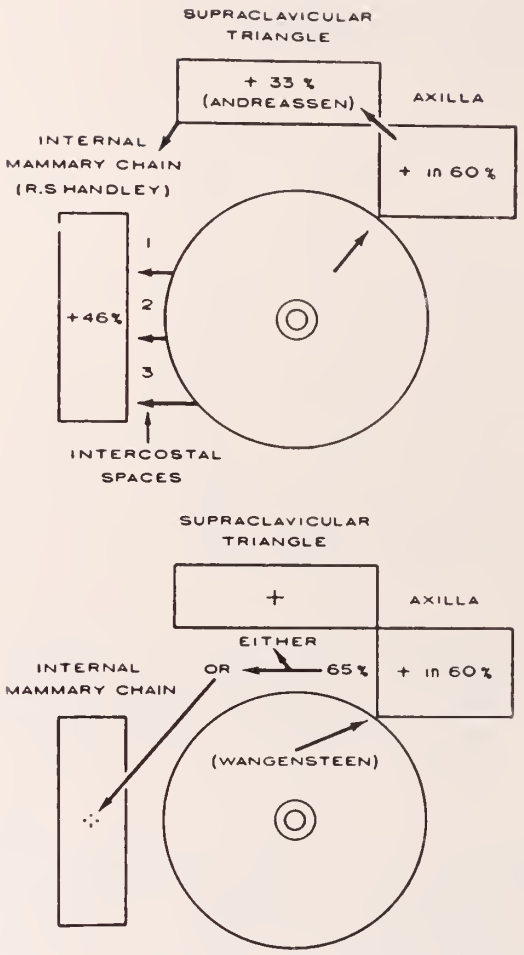


Figure 2. Diagrammatic Representation of Frequent Failure of Classical Mastectomy to Eradicate Cancer (after Ash, et. al., The Argument for Preoperative Radiation in the Treatment of Breast Cancer) Reproduced by permission of the authors and the publishers of S. G. & O.

cancer is in doubt. For example, if one were engaged in a neck dissection for carcinoma primary above the clavicle, it is questionable whether one would be satisfied with the type of lymph node dissection of the supraclavicular fossa that the Wangensteen operation provides. In addition, little is known about the anatomy and physiology of the mediastinal lymphatic system except that it forms a very tenuous and brief interval between the thoracic and pectoral lymphatic systems and the immediate venous return to the right heart. The mediastinal fat and areolar tissues are certainly not susceptible to block resections as are those of the axilla, therefore considerable doubt must exist in the mind of the surgeon as to just what he is accomplishing anatomically and therapeutically by the piecemeal removal of such tissues in a Wangensteen-type dissection.

Urban[9], stimulated by the work of Handley and Thackray[10], has been impressed with the frequency of the spread of central and inner quadrant lesions to the internal mammary lymph nodes. He has devised an operation for resection of the homolateral internal mammary lymph node chain combined with a classical radical mastectomy, which seems to fulfill all of Halsted's original tenets concerning the ideal resection for cancer. In Urban's operation, a block segment of anterior chest wall containing the internal mammary chain is resected in continuity with the main mastectomy specimen (Figure 3). No formal attempt is made to clean out the supraclavicular fossa although an extension in this direction could very easily and practicably be made if desired by dividing the clavicle. The operation is readily done by any well-trained general surgeon, the morbidity is not markedly increased, the mortality is no greater than that of a Halsted mastectomy, and to date is nil in Urban's series of 100 cases.

There are several objections to the operation, however. First of all, a full thickness segment of chest wall must be removed in order to be sure of including the fragile, and almost invisible internal mammary chain (Figures 3 & 4). The defect in the chest wall, and the maneuvers to cover it by centrally displacing the opposite breast, produce unpleasing deformities. The fear of flaps sloughing, especially those utilized to cover the chest defect, results in an unconscious tendency on the part of the operator to cut thick viable flaps, and to be niggardly in removing skin so as to avoid grafting; defections which are condemned by serious students of mastectomy technique. As with the Wangensteen procedure, the increased magnitude of the operation tends to make the surgeon unconsciously slight the mastectomy itself which is last in the sequence of operative events in both techniques, but which still remains the most important part of either operation.

The most telling argument against Urban's procedure, however, arises from the great anatomical disparity between the axillary and internal mammary lymphatic systems. In the former, a dense meshwork of more than 60-70 lymph nodes, lymph aggregates and numerous intercon-

necting lymphatic channels, one has a massive lymphatic filtration system which can very practically be removed in one block by a meticulous circumscribing scalpel dissection. The internal mammary group which is a bilaterally paired, closely aligned chain with undoubted cross communications, consists of a total of from three to seven minute (Figure 4), almost microscopic lymph nodes, and their filamentous connecting channels, necessitating a block resection of the chest wall in which the chain lies in order to be sure of complete removal. It is logical to assume that in many instances, breast cancer can become so trapped and arrested in the formidable axillary network that complete or nearly complete extirpation can be done by the meticulous block dissection of the axilla which is a characteristic part of the Halsted mastectomy. It is not possible for anyone who has often dissected out the internal mammary lymphatic system to conceive that cancer can be trapped, arrested, or even halted briefly in its passage through this filamentous web. It is more likely that the presence of cancer in the internal mammary nodes is merely a warning signal that the train of cancer has passed along the track, and gone beyond, so to speak, and it would therefore be illogical to assume that anything of a curative nature is accomplished by the block resection of the homolateral half of the internal mammary chain as in the Urban operation.

As Rowland Handley has stated, important information as to the spread of cancer can be obtained from biopsy of the internal mammary nodes; information that may drastically alter the composite attack on the individual breast cancer case under consideration. Haagensen, for example, considers that demonstrable involvement of these nodes indicates that the case is categorically inoperable, or at least unsuited for radical mastectomy[11]. Handley feels that internal mammary metastases indicate the need for post-operative roentgen therapy to the mediastinum after the radical mastectomy has been done[10]. One would hardly feel justified in doing a block segmental resection of the chest wall solely to obtain such information.

Adrenalectomy in Breast Cancer

For some time, it has been known that certain mammary cancers regress following oophorectomy, and recently it has been established that these are estrogen-dependent cancers. After total oophorectomy, estrogen, sometimes in large amounts, is still produced and it is thought that the adrenal cortex manufactures either estrogen or estrogen precursors. After total adrenalectomy in such ovarian-ablated cases, estrogen production apparently ceases entirely[12,13].

In the past three years, clinical and laboratory research at several centers has established the fact that certain advanced



Figure 3. The Urban Operation for Resection of Internal Mammary Chain with Mastectomy (after Urban (9) Reproduced by permission of the author and the publishers of Cancer.

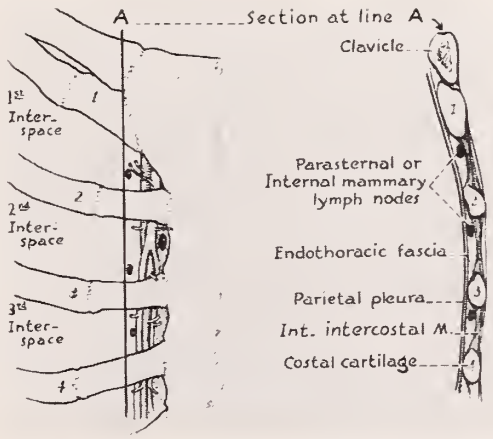


Figure 4. The Internal Mammary Lymphatic Chain (after Haagensen, et. al. (11) Reproduced by permission of the authors and the publishers of Surgery.

mammary cancers are favorably influenced by the total cessation of estrogen production resulting from total adrenalectomy either with or without ovarian ablation. In the centers where this procedure has been carefully and thoughtfully employed, the results of this therapeutic attack upon advanced breast cancer show a remarkable overall statistical uniformity[13,14,15]. It is regrettable that these results have been somewhat loosely described and uncritically presented, particularly in recent lay publications.

Summarized briefly, slightly less than 40 per cent of women with duct cell cancer of the breast, with advanced osseous and pleural metastases obtain a remission following total adrenalectomy, with or without oophorectomy. It is important to scrutinize carefully the character and duration of these remissions. Generally speaking, the remission is characterized by decrease or disappearance of bone pain, apparent cessation of progression of bone metastases and mastectomy scar recurrences, and in a very few, measurable regression of secondary cancer deposits in bone and scar occurs. It is generally agreed that hepatic metastases are unaffected and actually progress after total adrenalectomy, as do certain soft tissue metastases. It is agreed also that while certain bone lesions appear to regress, other contiguous or neighboring bone lesions simultaneously advance.

The duration of these remissions is also important. All centers reporting such cases calculate their remissions in days and include a large number of remissions of 30, 60, 90, and 180 days. In each series, however, there are a few cases that have been in remission for many months up to two years. It would be most interesting and valuable to have an appraisal of such long-term remissions as to whether or not prior treatment had been adequate in the light of our present day knowledge, and whether it had included such adjuncts as adequate radiotherapy, hormone therapy, and bilateral oophorectomy in proper sequence, dosage and duration. As yet, such appraisals have not appeared in the medical literature. Unfortunately and probably inevitably, each small series yet available includes unselected cases which have had little or no adequate cancer therapy prior to adrenalectomy.

In Huggin's series[13], only 7 out of 50 cases are in remission up to two years, the remainder being dead or dying with advancing cancer. One can certainly question the place of so extreme a procedure as total adrenalectomy in the therapy of advanced breast cancer when remissions for as long or longer intervals can be obtained by conservative measures such as radiotherapy, bilateral oophorectomy and hormone therapy. It is important to realize also that adrenalectomy fails to be complete and is, therefore, not effective, in the considerable percentage of patients who have accessory adrenal tissue. It is most important to learn what total adrenalectomy and perhaps hypophysectomy can accomplish in adequately treated cases with advanced osseous metastases which have had all of these previously mentioned attacks thoroughly and conscientiously carried out and in which cancer is still advancing.

Huggins has described the procedure of adrenalectomy as the substitution of a controllable disease, namely, Addison's Disease, for an uncontrollable one, namely, advancing breast cancer, and intimates that the management of the totally adrenalectomized patient is routinely practical. Despite our new knowledge of adrenal function and the present availability of numerous synthetic adrenal-cortical-like compounds for the maintenance of such patients the long term management of the totally adrenalectomized patient by the average practitioner or internist is not without grave risk.

Summary

Three important surgical experiments in the modern treatment of breast cancer have been presented. Two are operations of extreme radicality made possible only by brilliant advances in surgical, anesthesiological and physiological knowledge and technique. The third experiment is a surgical procedure which, while technically not too difficult, has only been made possible in human patients by the recent discovery and perfection of synthetic adrenal-cortical-like hormones and pituitary adrenocorticotropic-like hormones which serve to keep the adrenalectomized and hypophysectomized patient alive.

These three surgical experiments have this in common. Technically, they are within the ability of the average, well trained, general surgeon to perform, and they, therefore, can be, and are beginning to be offered, by surgeons of practical experience and skill to patients throughout the countryside; not necessarily in medi-

cal centers where the selection and observation of patients, and the careful impartial follow-up that is so necessary for evaluation of results, can be assured. It poses a pretty problem in moral responsibility as to whether or not these procedures should be utilized by the general surgeon in private practice entirely divorced from such large centers. My own feeling is that they are still surgical experiments, promising though they seem. No one can honestly say at this time that any of them cure or arrest breast cancer to any significant degree. Since the life cycle of untreated breast cancer approximates forty-two months, and since the longest survivals following the operations of Urban and Wangensteen are as yet no greater than thirty months, it follows then, that nothing is known about the curative effects of either of these extensive anatomical dissections.

The place of adrenalectomy is quite different, it being a palliative procedure only. Its exact status as regards the degree of palliation offered as compared with the risk involved is not established. Its further relationship to the treatment of progressive or advanced breast cancer as regards its influence on the response of the cancer to established forms of therapy if adrenalectomy were to be employed early in the course of stage III cases cannot be known for many years and perhaps will never be known. At the present time, adrenalectomy offers a remote chance for palliation in a small percentage of terminal breast cancer cases. The duration and degree of palliation is unpredictable, and the moral benefit accruing to patient, family and community is obscure.

While it is exceedingly important that these experiments continue in the centers where rigid control, careful observation and efficient follow-up is possible on a scrupulously impartial basis, nevertheless, it would seem that at the present time the physician or surgeon exclusively in private practice has a moral responsibility to his patient with breast cancer to refrain from urging or performing super-radical operations such as those of Wangensteen or Urban, until further information is available as to just what they accomplish. He should likewise, I think, beware of urging or performing total adrenalectomy for desperately ill patients with advanced or even terminal breast cancer. Alternatively, one might most cautiously offer the procedure as a possible desperate chance for relief to such patients, who, with a full understanding of the facts, are willing to take the risks involved, by having the operation performed at a center, where such procedures are being customarily performed and evaluated on carefully selected cases.

To quote Dunphy[16], "The application of this and all other superradical procedures for extensive cancer might be more judiciously applied if the operating surgeon were required to follow all these patients personally regardless of the outcome. A significant share of the emotional and economic burden that such operations produce would have a salutary influence."

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Cancer—Before the Cancer Age

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Louisville

"In the day when the keepers of the house shall tremble, and the strong men shall bow themselves, and the grinders cease because they are few, and those that look out of the windows be darkened."[1] Thus the Biblical writer poetically paints the picture of the aging man and from high places in medicine has come the customary relating of carcinoma with age. This is not to be a sermon, but we, and all teachers, I believe have overemphasized the importance of the carcinoma age group. Cancer has attained increasingly important status both in medical and lay thinking. It is difficult to state accurately the incidence of cancer, but the studies of Dorn[2] provide a basis for general statements relating to the United States.

On the basis of Dorn's work, about 230 new cases of carcinoma are diagnosed each year per 100,000 population. This means that out of roughly every 435 persons in the country each year, one person will be diagnosed as having carcinoma. Let's transpose this to our home towns or communities or to our practices and we shall see that we should statistically anticipate three new cases of carcinoma in the average town or practice of 1200 to 1500 persons per year. This can be, of course, carcinoma of any organ or system, and the law of averages will shift the numbers in communities from year to year.

Dublin[3] estimates that of every 100 white children born, ten males and thirteen females, or almost one-fourth of them will die of cancer. About 150,000 persons in the United States die of cancer each year.

In their studies at Memorial Hospital in New York, Pack and LeFebre[4] found that 86% of all neoplasms are malignant, that 90% of all malignant tumors are carcinoma and 10% sarcomas, and that the average age of patients with carcinoma is 53.8 years, sarcoma, 38.2 years.

If we may borrow a passage from Wm. Boyd's Textbook of Pathology[5] in which he says "In the vision of Mirza Addison, described the masses of mankind crossing the bridge of life which spans the river of death and falling into the dark flood below. In the bridge there are many trapdoors—infantile mortality, typhoid, malaria, smallpox—through which the unwary traveler may drop, but these seldom open now. So large numbers approach the end of the bridge and drop through a small number of wide doors such as apoplexy, coronary occlusion and above all, cancer."

Malignancies of Early Life

Cancer is undeniably predominantly a disease of middle or old age, although some forms occur at a much earlier age. There is a group of malignant tumors which occur in early life or not at all. They occur in the retina, kidney, adrenals, and the central nervous system, such as sarcoma of the bladder neck or Wilm's tumor or embryoma of the kidney, most of which are observed before the fifth year. It may be said that embryoma or Wilm's tumor is the commonest abdominal malignant tumor of early childhood, usually occurring in the first three years of life and infrequently after five years of age.

Indeed, cancer looms large in the studies of infant and early childhood mortality, much larger than in former years, partly because of greater diagnostic acumen and in large measure the result of the reduction of infantile deaths from other causes.

Carcinoma of the liver is not considered in this paper, but in children the incidence of liver cell carcinoma to bile duct tumors is 18:1, whereas in adults, it is 5 or 6:1. In the Bantus who work gold mines in South Africa, carcinoma occurs almost exclusively in men under forty, but elsewhere, the anticipated cancer age is from forty to sixty. Most liver tumors in children are manifest before the end of the second year of life.

Certain tumors increase in frequency with increasing age, to the full life span of man. The more important of these are melanoma and carcinoma of the skin, carcinoma of the mouth and carcinoma of the prostate. Indeed, after 75 years of age, carcinoma of the prostate constituted 30% of all malignant tumors and it is estimated that if all men lived long enough they

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would develop prostatic carcinoma, but we have seen exceptions to the rule in, for example, a well developed prostatic carcinoma in a 42-year-old white male.

Although any tumor may be observed at any age, we must concede that most tumors have a peak incidence and are infrequently seen at other periods of life. Nevertheless, malignancies in early life tend to progress more rapidly, disseminate more frequently, and recur more often than do the same tumors in later life, and it becomes obvious why they should be sought out. The younger the patient, in general, the poorer the prognosis. In carcinoma of the breast, this influence of age on the grade of the tumor is well shown. In patients from eighteen to forty, 55% were grade III, while in patients from sixty-one to eighty, only 32% were of this high grade of malignancy[6].

"Age Group" Deviations

The purpose of this paper is to cite, without documenting specific examples, tumors of the usual carcinoma age groups that have occurred in younger or unanticipated ages and to plead for an awakening to the fact that age alone does not preclude the possibility of cancer. This small study has impressed the author with the growing group of malignancies in the young that has come to his attention.

Carcinoma of the thyroid does not specifically belong to this group because it has not been so dogmatically taught that this is a lesion of the carcinoma age group. Some authorities even go so far as to state that solitary nodules in the adult thyroid will prove to be malignant in 25% of the cases, whereas they will prove malignant in 100% of instances in children. Table I is a compilation of the cases from Louisville General Hospital and Norton Memorial Infirmary over a ten-year period, 1943-1952. Future years will see a considerable upward revision as we have become more conscious of thyroid carcinoma. In this paper, case examples have often come from other sources. One of these cases, a seven-year-old white male patient of Dr. Paul Hall, of Paintsville, showed the typical pattern of a papillary adenocarcinoma of the thyroid.

We are presenting no compilation of malignant tumors of the eye, ear, nose and throat, but we have an example in our files of a squamous cell carcinoma of the tongue in a week-old male child.

The pattern of distribution of ovarian malignancies is shown by Table 2, but variations of classifications place this organ outside the scope of this paper.

According to Schrek and Gates[7], the average age of epidermoid carcinoma is sixty-eight years, and of basal cell epithelioma, sixty years, but our table 3, shows some variation from this pattern. This chart does not separate basal and squamous epithelioma and as a result of coding divergencies, does not contain all cases. In World War II, we found that we were regularly confronted with squamous cell carcinomas of the lip in very young soldiers, especially if they had served several weeks in desert areas, and our files, contrary to the usual teaching, provide numerous examples of basal cell epithelioma in

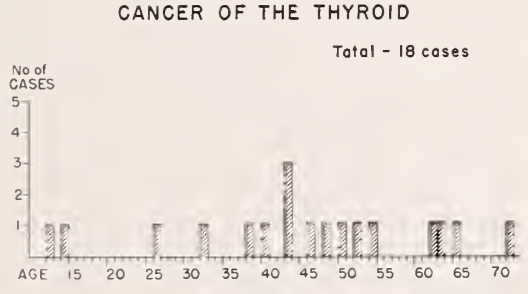


TABLE I

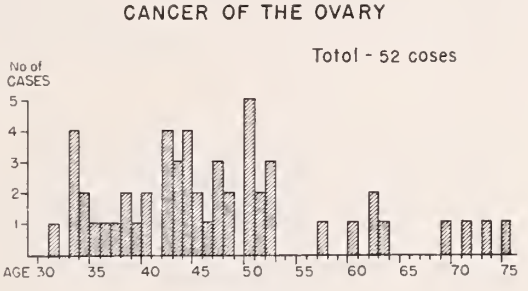


TABLE II

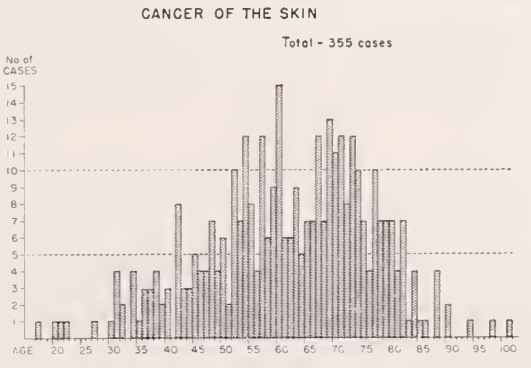


TABLE III

persons in the late teens and early twenties.

Carcinoma of the lung is rapidly increasing in importance, and if the autopsy statistics were included, the list, Table 4, would be much greater. However, notice that contrary to most published statistics, it is not a stranger to the younger age group and examples of bronchogenic carcinoma in a twenty-two and twenty-three year old have been sent to us by Dr. Gerald Fine, from the U. S. Naval Hospital, at Portsmouth, Virginia.

Carcinoma of the stomach has been reported in all decades, but in most surveys, over 70% are in persons older than 50 years. There is a preponderance in men of 2:1[8]. In men, carcinoma of the stomach is the most frequent malignant neoplasm, and in women, it ranks second only to carcinoma of the uterus and breast[9]. It is surprising to us that our statistics, Table 5, on carcinoma of the stomach, even if we include autopsy material, do not loom so large as in the usual national surveys, or in independent studies from other portions of the country. Our surgeons and internists assure us they are not turning away greater numbers because they are inoperable.

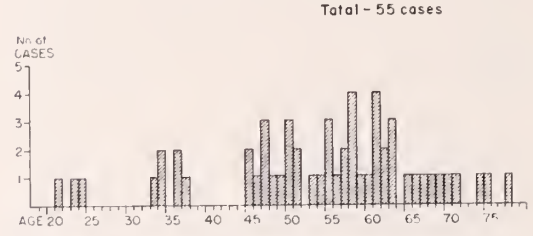


TABLE IV

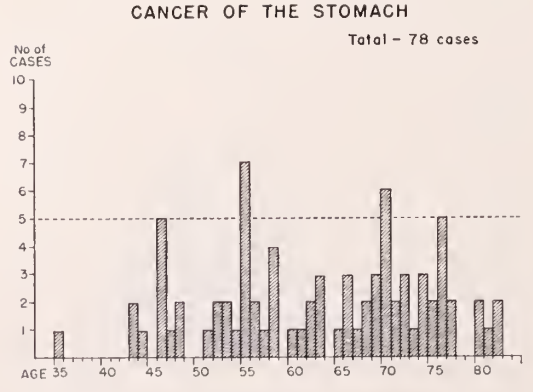


TABLE V

We have one case of a nineteen year old white female patient of Dr. James W. Archer, of Paintsville, who presented a pattern of anaplastic carcinoma. We seriously considered a malignant lymphoma, but the small nests of epithelial cells swayed us to the diagnosis of anaplastic carcinoma. This patient died about one year after operation with liver metastases. The absence of lymph node involvement or other evidence of lymphoma substantiated the diagnosis of carcinoma. Dr. Gerald Fine also supplied us an excellent example of an anaplastic carcinoma in a twenty year old patient.

About 85% of all carcinomas of colon and rectum are in persons over forty years of age, but the 5% below the age of thirty constitutes a significant percentage of carcinoma in young people. In general, carcinoma of the colon is somewhat more common in women, 3:2, and carcinoma of the rectum in men[10]. About 35% of all colons with carcinoma also have one or more polyps[11,12]. The relations of carcinoma and polyps is especially well illustrated in hereditary polyposis, in which there are many polyps, and the usual fate is carcinoma beginning in the third or fourth decade[13]. Carcinoma of the colon and rectum which are about equally divided between these two parts is regarded by most authorities as next to carcinoma of the stomach, the commonest carcinoma of the alimentary tract. Table 6 does not take into consideration the presence of polyposis.

Malignancy in the Female

In general, carcinoma seems to occur more frequently in breasts with proliferative and cystic lesions than in normal breasts, especially in the younger age groups[14]. Carcinoma of the breast is one of the more important diseases of human beings. It constitutes about 99% of all tumors of the breast, 15% of all malignant tumors in human beings, and 30% of all cancer in women[4]. According to MacDonald[15], carcinoma of the breast is rare before the age of twenty, 25% occur before the age of forty, and 42% between the age of forty and five years after menopause, and 32% more than five years after menopause. Our age distribution is shown in chart 7.

Carcinoma of the endometrium is largely a disease of women in the fifth, sixth, and seventh decades, the average age being about fifty-eight. About 70% are post-menopausal, and our Table 8 shows

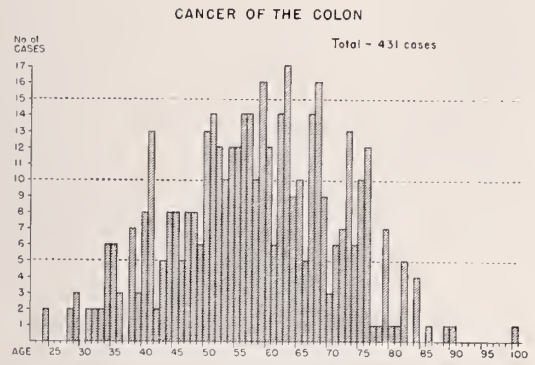


TABLE VI

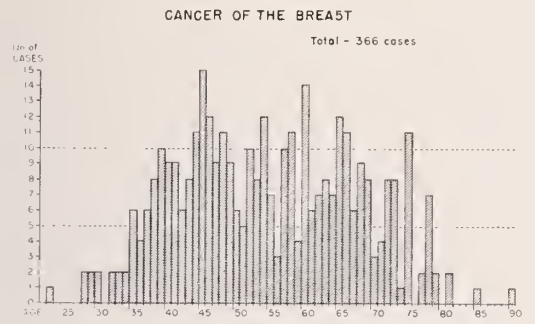


TABLE VII

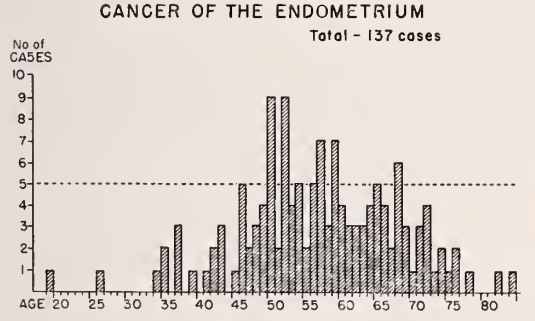


TABLE VIII

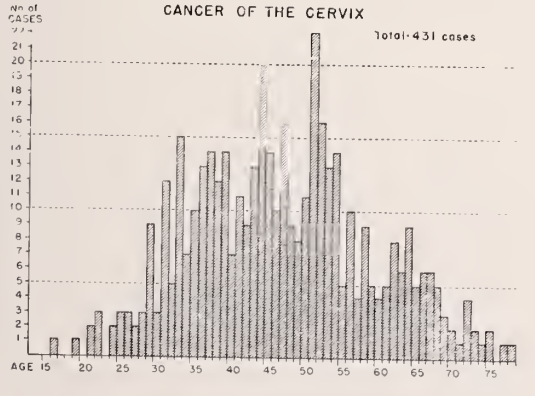


TABLE IX

not too many in the young. However, we have a case in a seventeen year old colored female, presenting a typical history.

Carcinoma of the cervix accounts for 25% of all carcinomas in women and causes the death of not less than 16,000 women each year in the United States. The highest incidence in most series is in the fifth decade, but all decades are seen, including the first. This disease looms large and here perhaps more than elsewhere, we see the importance of considering the young. Our group, Chart 9, does not include several interesting examples of cervical carcinoma in the young. Dr. Fine has supplied us with examples in twenty-three and twenty-four year old women. From Louisville General hospital, we have cases aged twenty-two and sixteen. Dr. A. J. Miller has recently provided us with an example of extensive cervical carcinoma from a fourteen-year-old girl.

If we may in closing once more quote Wm. Boyd, "when one considers the multiplicity of carcinogenic agents, it is easy to agree with Rous' remark that every animal possesses a myriad of potentialities for tumor formation, and only by good fortune do most human beings slip through life without the realization of a single one of them. If the individual chews betel nut in Siam, or warms himself with a Kangri in Kashmir, or paints luminous watch dials in the United States, he may spring the trap which is already set for him."

Summary

This paper, without documenting individual cases or suggesting possible carcinogenic agents, attempts to direct attention to the fact that although the vast majority of malignant neoplasms occur in middle or later life, one must not consistently accept the teaching that there is a carcinoma age and so complacently disregard suggestive signs and symptoms merely because the suspect patient has not reached the chronological age that we have been taught is "The Carcinoma Age Group."

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Methods for Reduction of Surgical Blood Loss

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Hemorrhage during the course of an operative procedure is one of the principal hazards of major surgery. For many years attempts have been made to find methods of reducing the possibility of blood loss without increasing the overall hazard to the patient. If such a technique were found and proven to be safe, surgeons could perform certain major abdominal and intracranial operations with greater despatch and improved technique. The necessity of administering large quantities of blood to the patient would no longer exist, and the possibilities of irreversible hemorrhagic and traumatic shock, as well as transfusion reactions and serum hepatitis, would be lessened.

In isolated instances deep planes of chloroform, ether or pentothal anesthesia have been employed to reduce blood pressure, and hence bleeding. The action here probably is a direct one on the vasomotor center. The degree of risk to the patient involved in such deep anesthesia does not justify the use of these drugs for this purpose. Bleeding can be reduced substantially in some instances by the use of posture, local injections of epinephrin and the application of tourniquets. These methods have their obvious limitations.

There are three other methods of reducing blood loss which have aroused much discussion recently. In all of them the goal is the same, i.e., reduction of arterial pressure so that bleeding from cut surfaces—arteries, capillaries and veins—will be lessened.

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Arteriotomy

The first of these was proposed by Gardner[1] and is known as arteriotomy. It consists essentially of withdrawing blood from the arterial system until the systolic blood pressure is about 80 mm. Hg. The situation is under control at all times, for if the pressure falls lower than desired, blood is reinfused into the arterial system through the same vessel from which it was withdrawn. The ischemia which is obtained with this technique is believed due at first to neurogenic vasoconstriction, which persists because of a non-filterable substance which is elaborated into the plasma[2]. It is probably the vasoconstriction rather than the low blood pressure per se which is responsible for the reduction in bleeding.

This method has been proven feasible, but its application has been limited to extremely vascular neurosurgical procedures for the most part. Its success depends on the production of what is equivalent to a relative hemorrhagic shock in the patient. Perhaps it is this degree of "physiological trespass" which has prevented its more widespread adoption.

Total Spinal Analgesia

The next two techniques result in a redistribution of the blood volume within the vascular bed. Total spinal analgesia has been practiced by a few anesthetists for a number of years, but not specifically with the idea of reducing blood loss. In 1929 Koster[3] reported on 4,500 cases of high spinal analgesia and concerning blood pressure stated: "In over 250 of our cases the anesthetist notified us that it was impossible to secure a blood pressure by manometer. Of late, when we receive

such information, nothing is advised. Our experience has taught us that ultimately the pressure will return and no untoward effect be occasioned as long as the patient remains in the Trendelenburg position." In 1942 Boume et al[4] reported on the use of high spinal analgesia for thoracic surgery in 282 tuberculous patients. Blood pressures remained at low levels during surgery, but the patients appeared to do well clinically. Rarely was it necessary to transfuse these patients with more than 500 cc. of blood. However, there were four deaths in this series of cases which could be related to the anesthetic technique.

It remained for Griffiths and Gillies in 1948[5] to recognize the possible advantages of total spinal analgesia in providing reduction of blood loss during surgery. The theory of action reasons that in total sympathetic block the arteriolar resistance is reduced greatly. Under such conditions a pressure of about 40 mm. Hg. suffices to maintain the capillary circulation, provided the total blood volume is normal and the inherent tone of the capillaries is not impaired, i.e., there is no anoxia of any type (chart I). The arterial pressure needs to be just sufficient to overcome the venous pressure and the colloid osmotic pressure of the plasma (about 32 mm. Hg.).

When this total reversible sympathectomy is combined with posture so that the operative site is highest, a dry surgical field will be provided without venous oozing. In order to safeguard the patient, it is recommended that two special precautions be taken:

(1) There should be gravitational drainage of venous blood from the extremities to ensure cardiac filling. In other words, the patient should be in the Trendelenburg position.

(2) Adequate oxygen saturation of the tissues should be maintained. This can be done by administering to the patient 100 per cent oxygen, assisting the respirations if this is thought necessary.

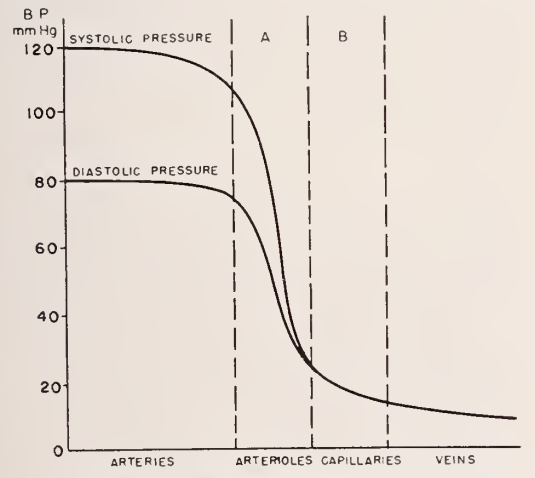


CHART 1

With total sympathetic paralysis, arteriolar resistance is reduced markedly, and a high systolic pressure is no longer required to sustain circulation.

Chemical Hypotension

The third method of achieving a reduction of arterial tension is by means of drugs. Paton and Zaimis[6], while investigating the methonium compounds, found that hexamethonium bromide and pentamethonium bromide were capable of producing hypotension. The pharmacology of these drugs indicates that they prevent transmission of impulses at the ganglionic synapse. They are drugs of remarkable specificity, acting in a competitive manner at the synapse itself, not on any pre- or post-ganglionic structure. They block both parasympathetic and sympathetic impulses. In so doing they abolish vasoconstrictor impulses throughout the body and thus induce a situation similar to that which is obtained with total spinal analgesia, as far as the sympathetic nervous system is concerned.

That a state of hypotension may be obtained in the patient by the administration of ganglionic-blocking drugs or by total spinal analgesia has been demonstrated many times within the last three years. Hampton, Little et al[7] have analysed a series of 21,000 patients so treated by anesthesiologists in Great Britain. That such a technique can be accomplished safely for the patient is open to some question. In the above-mentioned series complications attributable to the technique were seen in one out of 38 patients and the mortality rate was one in every 459 patients.

Case Reports

Our own experience has been somewhat limited in numbers and confined to the use of ganglionic-blocking drugs. All the patients were serious neurosurgical problems, most suffering from meningiomas, cerebral aneurysms or large vascular brain tumors. To date induced hypotension has

been utilized in forty-four patients, and in two of these mortality in the post-operative period has been thought to be related to the degree of hypotension or length of time it was maintained. In the above patients continuous arterial blood pressure records were obtained by means of an electromanometer connected directly to a needle or catheter in the radial artery. These direct readings were compared with the pressures obtained by the conventional blood pressure cuff. During the period of hypotension arterial pressure readings were also obtained from a cerebral artery.

Three ganglionic-blocking drugs have been injected to induce hypotension.

Figure I is the anesthetic record of a 35-year-old colored female who had a complete removal of an olfactory groove meningioma under nitrous oxide-oxygen and ether anesthesia, employing the orotracheal non-rebreathing technique. At number 3 on the record hexamethonium bromide,* 25 mgm. was injected intravenously. The blood pressure fell precipitantly, requiring a small amount of nor-epinephrin to return it to safe levels. Figure II shows the relationship between the cuff pressures obtained and the radial artery pressures. Satisfactory operating conditions were obtained in this patient, and it was necessary to give only 750 cc. of blood. The hypotensive effect persisted for several hours in the post-operative period, but otherwise convalescence was uneventful.

Figure III is the anesthetic record of a 44-year-old white male who had a right temporo-occipito-parietal craniotomy with biopsy of a metastatic brain tumor. Anesthesia was maintained with nitrous oxide-oxygen and ether given by the orotracheal non-rebreathing technique. Intracranial pressure was greatly elevated in this patient and after the operation began at number 5 on the record, only nitrous oxide-oxygen was necessary. At number 7 a slow drip of Arfonad,** 0.1 per cent solution, was begun, and after a total of only 12 to 13 mgm. a satisfactory hypotensive effect was obtained. This allowed the biopsy to be taken with little bleeding. Normotension returned in about twenty minutes with some assistance from nor-epinephrin.

*We are indebted to Burroughs, Wellcome Co. for supplies of this drug.

**We are indebted to Hoffman-La Roche Company for supplies of this drug.

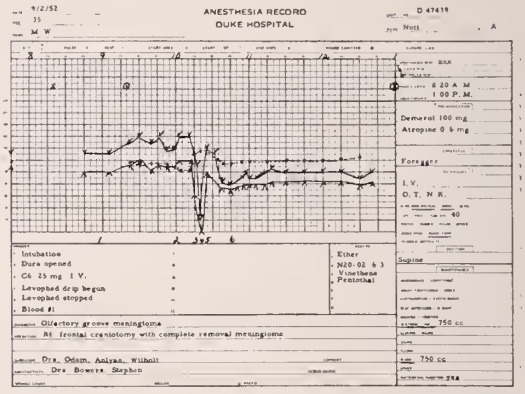


Figure 1. Marked hypotension achieved with hexamethonium bromide, 25 mgm. This was sustained for duration of operation. Nor-epinephrin required to compensate for acute fall in systolic pressure.

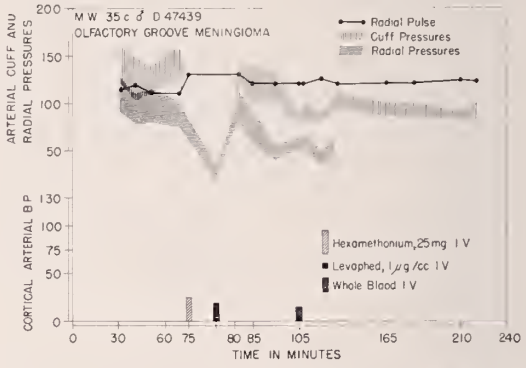


Figure 2. To show the discrepancy which may occur between conventional cuff and direct radial artery blood pressures. Cuff pressures may be absent entirely during marked hypotension, as above.

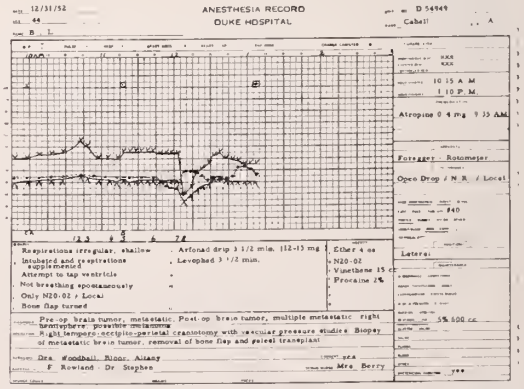


Figure 3. Arfonad, 12 to 13 mgm., produced adequate hypotensive effect for fifteen minutes.

Figure IV is the anesthetic record of a 24-year-old white female who was suffering from a recurrent ependymoma. Under nitrous oxide-oxygen and ether anesthetic, by means of the orotracheal non-rebreathing technique, a right fronto-temporo-parietal craniotomy incision was reopened with evacuation of a cyst and subtotal removal of a massive recurrent tumor. Just before hypotension was induced, this patient was placed in a 15° to 20° reverse Trendelenberg position. Blood pressure was reduced successfully by means of Pendiomide.* The original dosage was 30 mgm., and this was followed by intermittent repeated doses, as seen on the record, which totaled 125 mgm. in all over a period of 1½ hours. A satisfactory reduction in blood pressure and hemorrhage was obtained, although the patient required 1,500 cc. of blood. Blood pressure returned to satisfactory levels one hour after the last dose of pendiomide.

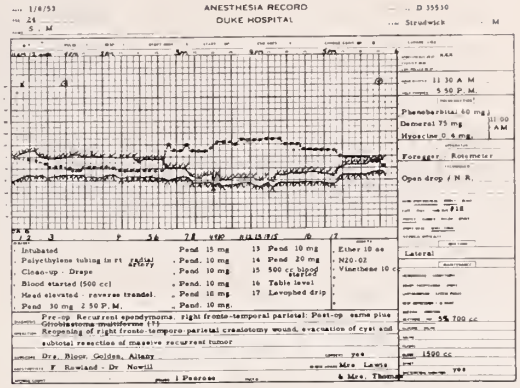


Figure 4. Intermittent administration of Pendiomide (total dose 125 mgm.) produced adequate hypotensive effect for 2½ hours. Pressure began to rise 1½ hours after final dose.

Discussion

A concept which purposely aims to produce during operation a degree of hypotension which for many years it has been the desire to avoid, is difficult to accept without reservations. Knowledge of the effects which acute or prolonged reduction in blood pressure have upon the vital organs and tissues of the body is of paramount importance. Substantiation of the theory proposed by Gillies and Griffith[5] that the peripheral vasodilatation associated with this technique allows adequate perfusion and tissue oxygenation should be forthcoming. Such investigations require time and a pooling of observations from numerous sources.

From our limited experience with ganglionic blocking drugs, several factors of practical significance have emerged. These may be described as interim observations:

On the positive side one may say:

1) Variable degrees of hypotension may be produced in patients by drugs which act at the ganglionic junctions. As a general rule, young vigorous patients require larger doses of the drug than do older arteriosclerotic patients. It is felt that in certain cases seen, surgery would have been impossible without this control over hemorrhage.
2) Bleeding can be reduced materially when adequate use of posture is combined with hypotension. If the tissues undergoing surgery are not elevated higher than the rest of the body, venous oozing may be a troublesome complication.
3) The degree of hypotension, as noted by Enderby[8], may be regulated to some extent by altering the posture of the patient. If the blood pressure falls too low with the table in the reverse Trendelenberg position, the situation may be helped by levelling the table.
4) Once the hypotensive state has been established, little supplementary anesthesia is required for maintenance.
5) Induced hypotension may be reversed rapidly by vasopressor drugs which act locally to constrict the peripheral vessels. Those which have been used most commonly are norepinephrin, vasoxyl and methedrine.
6) If one can maintain the systolic pressure between 60 and 90 mm. Hg., hemorrhage will usually be reduced substantially.

On the negative side of the picture, one may state:

1) There is a dearth of positive evidence as to what effect induced hypotension has on the functions of the vital organs of the body. Moyer et al[9] have commented favorably on the cardiac output and renal function of dogs after injections of hexamethonium bromide. Bromage[10] has submitted clinical evidence that, when the pressure falls below 60 mm. Hg. dur-

*We are indebted to the Ciba Company for investigative supplies of this drug.

ing hypotension, the liver swells and becomes dark in color, indicating inadequate circulation and function. One European investigator has shown that induced hypotension by a ganglionic-blocking drug (Pendiomide) reduces cerebral blood flow, but that this is compensated for almost completely by the associated vasodilatation. The inference is made that the arterial oxygen tension of the central nervous system cells is not reduced markedly.

2) The effect on the blood pressure of the patient of a given dose of a ganglionic-blocking drug is unpredictable. There is some possibility that this will remain so, because the variability in response reflects not so much an irregularity in action of the drug on the ganglia, as it does a variation in sympathetic tone from one patient to another.

3) If induced hypotension is to become practical clinically, more accurate methods than the present cuff mechanism must be found for recording blood pressure. When the patient's pressure falls below 60 mm. Hg., it is often impossible to see or hear any indication of what the pressure may be (Figure II).

4) Ideally the length of action of a hypotensive drug should be fleeting, but at the same time capable of continuation by intravenous drip titration. So far such a drug has not become available. Hexamethonium may exert its hypotensive effect for many hours. Pendiomide apparently is shorter-acting, but its ganglionic-blocking effect may persist for several hours. Arfonad probably has the shortest action of the three drugs, but a hypotensive effect from its administration may be prolonged for two hours after it is stopped.

5) The three drugs just mentioned all have the disadvantage of showing tachyphylaxis in some patients. The reason for this is unknown, but it places the administrator at a disadvantage as repeated doses cannot be counted on to have similar effects to the first or second doses.

6) During the state of hypotension it is important to maintain the blood volume. The patient under controlled hypotension is extremely sensitive to blood loss, as little as 200 cc. causing a drop in systolic pressure to dangerous levels. Administration of blood as it is lost is necessary in order to assure a safe level of systolic pressures. During the maintenance of a case the blood pressure tends to serve as a sensitive index to the amount of bleeding.

From the above information, it can be recognized that the instigation of this technique, in the light of the present lack of knowledge, probably does increase the overall calculated risk to the patient. The bounds of physiological rectitude are certainly approached and the possibility of exceeding them is very real. A decision to employ induced hypotension must be the result of a mutual discussion between surgeon and anesthesiologist. The hazards of hemorrhage in relation to the surgical technique must be weighed in balance with the loss of neural control over circulatory functions which is inherent in the technique.

Summary

1. Current techniques of reducing blood loss during surgical procedures are discussed
2. Examples are shown of hypotension by means of ganglionic-blocking drugs.
3. The hazards associated with employing this technique are summarized.

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Acute Pancreatitis

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The acute abdomen seen in the emergency room continues to present a problem to us all. One of the acute abdominal conditions which requires a differential diagnosis is acute pancreatitis.

Because of the difficulty in diagnosis and the controversial methods of treatment, our interest in this disease was aroused. A study of the records at St. Joseph Hospital, Lexington, Kentucky, from 1940 to 1952 was undertaken in an attempt to become more familiar with this condition. It is the purpose of this presentation to discuss the findings of this study.

History

Klebs in 1870 recognized acute pancreatitis as a cause of "fulminant death" and stressed its pathological importance. Claude Bernard in 1856 reported the production of experimental acute pancreatitis and the early death of animals following the injection of bile and olive oil into the pancreatic duct. Rokitansky in 1863 carefully recorded the pathological appearance of acute pancreatitis and Friedreich in 1878 published the first well defined and complete description of the disease. Reginald Fitz's classical description of acute pancreatitis in 1889 was a monumental contribution to the literature on this condition. However, his description was based upon the necrosing variety of pancreatitis and some conclusions drawn have since been clarified. At the turn of the century such men as Korte (1898), Oser (1898), Mayo-Robson, Moynihan and Opie (1903) contributed much to our present day knowledge of the disease.

Etiology

The classification of Siler and Wulsin serves to illustrate the complex and numerous theories which have been advanced concerning the etiology of acute pancreatitis.

1. Reflux of bile into pancreatic ducts: This explanation involves obstruction of the ampulla of Vater producing reflux of bile into the pancreatic ducts in the presence of a common communication between the terminal bile and pancreatic ducts.

Opie in his now famous autopsy, found an impacted stone in the ampulla of Vater and by compressing the gall bladder was able to force bile into the pancreatic ducts. Later he experimentally found that pancreatitis could be produced by injecting bile into the duct of Wirsung. Archibald, Popper, Lium and Maddock, Howard and others have reproduced these results. This led to the hypothesis of a "common channel" existing between the terminal ends of the bile and pancreatic ducts. The presence of a common channel permitting reflux of bile into the pancreatic ducts has been variously reported. Rienhoff and Pickrell report a low incidence of 69 per cent while Opie reports a high incidence of 89 per cent.

Because of the relatively low incidence of stones present in the biliary tree in cases of acute pancreatitis Archibald attempted to explain it on the basis of spasm of the sphincter of Oddi. Schmiden and Sebening found ampullary stones present in only 4.4 per cent of patients with acute pancreatitis. Doubilet and Mulholland have demonstrated that spasm would more readily produce an effective common channel in susceptible individuals than would a stone. Suffice it to say here that although there are objections and doubts as to the validity of the common channel theory, it remains the most plausible explanation yet advanced.

2. Obstruction of the pancreatic ducts: It has been known since the time of Opie in 1900 that obstruction of pancreatic ducts by calculi, tumor or inflammation, epithelial metaplasia, ligatures and duodenal diverticulum may produce pancreatitis.

3. Infectional Theory: Invasion of bacteria by migration from the duodenum is a plausible theory but lacks clinical support.

4. Vascular Factors: It is more generally accepted that the pathological vascular picture seen in acute pancreatitis is the result of the disease rather than being the etiology itself. There are those who contend however, that pancreatitis is a result of thrombosis of the vessels in the pancreas.

5. Trauma: Isolated incidents of trauma, accidental or surgical, precipitating acute pancreatitis have been reported and must

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be assumed to produce the disease on occasions. Shallow and Wagner believe that trauma accounts for 2-4 per cent of the cases of acute pancreatitis.

6. MISCELLANEOUS: Duodenal contents entering the pancreatic ducts, alcoholism and anaphylaxis have all been advanced as causing acute pancreatitis. Clinical data is lacking to assume that all acute pancreatitis is caused by any one of these factors although isolated incidents have been reported.

Pathology

The gross pathological picture in acute pancreatitis varies from one individual to another but it is assumed that the chain of events is as follows: pancreatic edema, fat necrosis, hemorrhage, pancreatic necrosis and suppuration. Cole, Cattell and Warren believe that pancreatic edema and necrosis are but differing degrees of the same process.

In pancreatic edema the gland appears grossly distended with the lobulations more pronounced. Isolated areas of involvement are common and the head of the pancreas is most often affected. The overlying peritoneum may be elevated by the interstitial fluid. If the pathological process stops at this point, which it commonly does, the inflammatory reaction subsides and little permanent damage is done. If on the other hand the process progresses, pancreatic necrosis develops.

Action through the pancreatic lipase upon tissue produces fat necrosis which is clinically evidenced by white, opaque plaques in the peritoneal cavity. The enzyme splits fat into glycerin and fatty acids, the latter combining with calcium to form insoluble soaps.

It is the general concensus of opinion that hemorrhagic pancreatitis is the result of escaping ferments and that the extent of the process is dependent upon the caliber of vessels which are involved by this action. Popper, Necheles and Russell have demonstrated that when the arterial supply of the pancreas is interrupted in the presence of pancreatic edema changes from intraperitoneal fat necrosis to severe hemorrhages or necrotizing pancreatitis will occur.

As a general rule the hemorrhage is scattered throughout isolated areas of the gland and varying stages of the process are seen in one particular gland. Areas of edema, hemorrhagic exudate, red blood cells and cellular disintegration are seen on the microscopic picture. The hemorrhagic phase of the disease accounts for the dark, bloody peritoneal fluid which may be present and for the discoloration in the flank and about the umbilicus.

Pancreatic necrosis follows the hemorrhagic phase and is characterized by cellular disintegration and loss of substance of the gland. Edema and hemorrhage are usually seen confluent with the necrosis and areas of sloughing and gangrene are present. These processes are microscopically surrounded by leucocytes.

Suppuration is the end stage of the process and is regarded as a complication rather than an actual phase of the disease.

From the period of 1940-1952 there were 48 patients discharged from St. Joseph Hospital, Lexington, Kentucky, with the diagnosis of acute pancreatitis. Of these cases 15 were excluded in this series because of insufficient proof of the disease. This series includes the remaining 33 cases of proved acute pancreatitis. There were 9 cases in the 1940-1945 interval, 18 cases in the 1945-1950 period and 6 cases in the 1950-1952 interval.

Diagnosis

Confirmation of acute pancreatitis in this series was by surgery in 16 cases or 47 per cent, by post mortem examination in 9 cases or 26.5 per cent and by elevated serum amylase in 9 cases or 26.5 per cent.

Surgical confirmation of acute pancreatitis was considered only when a biopsy was taken or the operative note left no doubt as to the pathology present. Confirmation at necropsy must be considered in any series. When considering the diagnosis of acute pancreatitis by means of the serum or urinary amylase one must be aware of the limitations of these tests. Within the first several hours the level may be normal or only slightly elevated but there should be a prompt rise to a maximum level within 24 to 48 hours and a rapid decline to normal after 72 hours from the initial onset of symptoms. The rapid decline is just as significant as the prompt elevation. The urinary amylase is normal early in the disease rising more slowly and remaining elevated after the serum amylase has returned to normal. Both of these measures should be utilized in following the patient.

In a review of the records for the purpose of this study those cases with an isolated serum amylase of above 300 were in-

cluded, as well as those with any series of tests which showed the characteristic curve. No positive urinary amylase studies were found.

It is realized that because of the nature of these tests certain cases of acute pancreatitis were not utilized in this study because of the lack of an elevated serum amylase, some patients undoubtedly being seen after the period the serum amylase would be positive.

In the 1940-1945 period, 6 cases were confirmed at surgery, 3 at necropsy and none by the laboratory. In the 1945-1950 interval, 5 cases were confirmed at surgery, 5 by necropsy and 8 by the laboratory. In the 1950-1952 period 5 cases were confirmed at surgery, none by necropsy and one by laboratory procedure.

Age and Sex

In this series the average age of patients was 51.0 years the youngest being 9 years of age and the oldest 86 years. This is slightly higher than the series reported by Paxton and Payne. MacGuire and Conte found an average age of 47.5 years. Morse and Achs in a review of 154 cases showed that 50 per cent were in the 4th or 5th decade.

There were 18 males and 15 females in this series a point which is similar to other reported series. Molander and Bell however, report 68.7 per cent female and 36.3 per cent males and this predominance of females being affected is supported by Payton and Payne.

Symptomatology

Payton and Payne have divided patients into five groups which properly illustrate the varied symptomatology present in acute pancreatitis.

Group 1. (classical picture) This is the middle aged, obese individual having severe excruciating epigastric pain with persistent nausea and vomiting followed by cyanosis and shock. Death ensues rapidly.

Group 2. Those cases resembling acute cholecystitis. The onset is acute but to a lesser degree and may localize in the right upper quadrant with radiation into back.

Group 3. Cases suggestive of small intestinal obstruction. These patients have abdominal pain, persistent nausea and vomiting and obstipation.

Group 4. Cases simulating acute gastritis or perforated ulcer. There is usually history of alcoholic ingestion in these cases.

Group 5. Patients in whom tenderness or a mass develops in the upper abdomen.

Abdominal pain is the predominant symptom. In the presence of pancreatic necrosis it is quite severe and located in the epigastrium or to the left of the midline. It is particularly resistant to narcotics and it is present in over 90 per cent of the cases reported by Payton and Payne, Morton and Widger. In this series pain was present in 93 per cent of the cases.

Nausea and vomiting appear early and are persistent and prolonged, contributing to dehydration. Vomiting is rarely fecal in nature being characteristically gastric content. Lewison reports an incidence of vomiting in 71 per cent of his patients. In the present series vomiting was present in 93 per cent of the cases.

Obstipation and abdominal distention are prominent features of the disease, particularly in the necrotic phase. Progressive distention is a bad prognostic sign. Puestow, Looby and Risley report 100 per cent occurrence of abdominal distention and Morse and Achs 56 per cent. In this series it was present in 72 per cent.

In the present series the chief complaints on admission were as follows: 1. epigastric pain, 13 cases or 39 per cent. 2. generalized abdominal pain, 9 cases or 28 per cent. 3. right upper quadrant pain, 5 cases or 15 per cent. 4. nausea and vomiting, 3 cases or 9 per cent. 5. No specific complaint, 2 cases or 6 per cent. 6. shock, 1 case or 3 per cent.

The chief complaint on admission was abdominal pain of some nature in 82 per cent.

Signs

As a rule the symptoms are out of proportion to the signs and this point may be a helpful aid in the diagnosis.

Despite the severe pain, nausea and vomiting, the tenderness may be minimal. Abdominal tenderness of some degree was present in 90 per cent in this series.

Peristalsis early is normal and may be helpful in differentiating from a ruptured ulcer. After about 12 hours it becomes diminished. Abdominal distention of some degree was present in 15.1 per cent of cases in this series.

A palpable mass may or may not appear. Cattell and Warren report an incidence of mass of 15 per cent in their series and in the present group a mass was present in 12.1 per cent of the cases.

Clinical shock as evidenced by fall in blood pressure, rapid pulse, cyanosis and

collapse is now thought to be relatively uncommon despite reports to the contrary. Payton and Payne report 11.7 per cent while Morse and Achs report 17 per cent. Clinical shock was evident in 33 per cent of cases in this series.

Moderate fever usually accompanies acute pancreatitis.

Jaundice has been reported as being present in 25 per cent of the cases according to Fallis, Koster and Dasman and 27 per cent by Morse and Achs. It was present in one case or 3 per cent of this group.

Cullens sign or peri-umbilical discoloration and Grey Turner's sign or flank discoloration have been reported as signs of acute pancreatitis. These signs are thought due to the retroperitoneal extravasations of hemorrhagic debris and their importance lies in the fact that either is a poor prognostic sign. Grey Turner's sign was present in one case of this series.

Treatment

It is now generally recognized that the treatment of this disease is primarily medical although it is wrong to apply conservative treatment to all cases with rigid conformity. In the present series of cases 14 or 42.5 per cent of the total were treated medically and 19 or 57.5 per cent treated by operative intervention.

Medical Treatment

The medical treatment is based upon awareness of the sequence of events which develop in the pancreas proper and the body in general.

The disease requires the liberal use of opiates. Morphine and its derivatives by inducing spasm of the sphincter of Oddi are theoretically objectionable. Demerol is considered the best agent by many. Antispasmodics, such as atropine, are given in an attempt to reduce the spasm of the sphincter of Oddi and reduce pancreatic secretions. Banthine has recently been advocated for this purpose.

Gage strongly advocates the use of coeliac ganglion blocks for relief of pain because of the stress which this symptom places on the body in general. Continuous epidural block, after the technic of Hingson and Southworth, with or without the ureteral catheter has been used for this purpose. Coeliac ganglion block was done in three cases of the present series, all with beneficial results.

An important phase of the medical treatment is the restoration of a normal blood volume. There is usually a hemoconcentration as evidenced by the hematocrit, reflecting a loss of plasma. This should be corrected by use of plasma or whole blood and intravenous glucose used to supplement the plasma.

Needless to say the administration of antibiotics is of extreme importance to inhibit the growth of bacteria in an already damaged organ.

A refractory ileus undoubtedly contributes to the mortality and should be controlled by upper intestinal syphonage. Segmental dilation of a loop of jejunum has been pointed out as one of the early signs of the disease. Some authors advocate the prophylactic use of the Miller Abbott tube to prevent distention. Most however, are content with gastric suction alone.

Suppression of pancreatic secretions should be accomplished by atropine or Banthine, nothing by mouth, and gastric suction. Cattell and Warren have recently suggested the utilization of X-ray therapy in an effort to diminish the pancreatic secretions.

Close observation for an alteration in the glucose metabolism is required and correction immediately instituted when necessary. Signs of liver disturbance also should be observed and corrected.

A deficiency of calcium should be anticipated, the low level occuring about the sixth day. Correction should be by parenteral calcium because of the poor absorption of this mineral by the gastrointestinal tract.

14 cases or 52.5 per cent of this series were treated conservatively with a 50 per cent mortality. This is much higher than generally reported. However, an analysis of these cases illustrates the reason for this unduly high mortality in this series.

In case No. 17 the duration of the present illness was unknown, the patient was in critical condition on admission with shock, a rigid abdomen and fluid present in the abdomen. The duration of the present illness in case No. 26 was 168 hours, the patient was in critical condition with alkalosis, fluid in the abdomen and shock. Case No. 28 showed the present illness to be present for an undetermined length of time, his condition was in extremis with signs of alcoholism. Case No. 30 had been sick for 48 hours, his condition on admission was classified as good but he soon developed a rigid abdomen, distention and Grey Turner's sign. The duration of pres-

TABLE I
MORTALITY FOLLOWING MEDICAL TREATMENT
TOTAL 7 CASES

CASE	AGE	RACE	CHIEF COMPLAINT	DURATION P.I.	CONDITION ON ADM.	PHYSICAL EXAMINATION
#17	70	W	Abdominal pain	Unknown	Extremus	BP 80/40, P 110, rigid abdomen with fluid present
#26	9	W	Convulsions with diff. breathing	168 hours	Extremus	Alkalosis, shock (BP unobtainable) fluid in abdomen
#28	45	W	Alcoholism	Unknown	Extremus	BP 98/40, P 120 Alcohol on breath, coma, rigid abdomen
#30	58	W	Abdominal pain, severe	48 hours	Good	BP 110/68, P 90 on admission. Within first 24 hrs., developed rigid abdomen with fluid and shock.
#36	57	W	Coma	Unknown	Extremus	BP 90/50, P 110 coma, fluid in abdomen (?)
#39	37	W	Vomiting and abdominal pain	120 hours	Critical	BP 80/40, P 120 T 96°, No peristalsis, no abdominal tenderness.
#42	45	W	Abdominal pain alcoholism	Unknown	Extremus	BP 98/42, P 116, 4 plus rigidity and tenderness epigastrium.

ent illness in case No. 36 was unknown, the patient was in extremis on admission. Case No. 39 had been sick for 120 hours and her condition on admission was critical, with shock which rapidly became more severe. Case No. 42 had a present illness of unknown duration, the patient was in coma and deep shock on admission.

It was evident therefore that only one case was presented for treatment within the first 48 hours, the remaining having medical attention after the disease had progressed to the advanced stage. Effective medical treatment is dependent upon early diagnosis and institution of treatment. Of the patients who survived under conservative management, only one was seen over 72 hours after the initial onset of symptoms, the remaining being seen within the first 24-48 hours. Failure on part of either the patient or physician to institute early treatment accounts for the unduly high mortality rate present in the patients treated with conservative measures.

Surgical Treatment

In spite of the fact that medical treatment is preferred, there are instances in which surgical intervention is necessary. Cole has advanced the indications for immediate surgical intervention to be: 1. when the diagnosis is uncertain, 2. when signs of peritonitis are present, and 3. when the disease is complicated by an abscess or hematoma. He further believes that surgery is contraindicated when: 1. the diagnosis is certain, 2. in cases with severe vascular collapse and 3. when the inflammatory reaction appears to be confined to the retroperitoneal tissues.

Cattell and Warren advocate minimal exploration and drainage of the retroperitoneal space when a patient with acute pancreatitis is mistakenly operated upon. However, associated gall bladder stones require a cholecystectomy or cholecystostomy depending on the condition of the patient. A stone in the common duct necessitates a choledochostomy.

Whenever possible however, surgical intervention should be delayed until the acute process is over and limited to those who have associated stones in the biliary tree. The common duct should be explored in all of these cases on the basis of the "common channel" theory. Drainage of the retroperitoneal space for progressive flank edema and accumulated fluid also falls into the category of delayed operative treatment.

Of the operative procedures in the present series 31 per cent were cholecystectomies, 10 per cent cholecystostomies, 10 per cent cholecystectomy and common duct exploration, cholecystostomy and common duct exploration 5 per cent, abdominal exploration 16 per cent, draining of the pancreas in 21 per cent and closure of ruptured ulcer in 5 per cent.

There were 19 cases or 57.5 per cent treated by operative intervention either through mistaken diagnosis or with full knowledge of the disease.

Eleven cases were operated upon for stones in the biliary system and one for a ruptured duodenal ulcer. In all of these cases an associated pancreatitis was discovered.

The remaining seven cases or 36.7 per cent of those operated upon underwent exploration without knowledge of the true pathology present.

There were four deaths or 21.0 per cent following surgical intervention and two or 10.5 per cent of these deaths occurred in the group undergoing surgery for mistaken diagnosis.

An analysis of the deaths illustrates this point.

Case No. 22 was admitted with the diagnosis of acute cholecystitis 48 hours after the onset of symptoms. The gall bladder was found to be normal and the pancreas drained. Surgery possibly could have been avoided by use of the serum amylase.

Case No. 29 was admitted with the diagnosis of ruptured peptic ulcer and at surgery a ruptured duodenal ulcer was found associated with a necrotic pancreatitis. In this case surgery was definitely indicated.

Case No. 34 had the admitting diagnosis of ruptured peptic ulcer but a hemorrhagic pancreatitis was found at surgery and a cholecystectomy and common duct exploration was done for stones in biliary system.

Case No. 37 was a 73-year-old man whose admitting diagnosis was ruptured peptic ulcer. He was seen 5 hours after the initial onset of symptoms with a rigid abdomen. Peristalsis was normal and there was flank dullness. At surgery a hemorrhagic pancreatitis was found.

Case No. 22 and No. 37 were operated upon because of a mistaken diagnosis.

The overall mortality for this series was 33 per cent. In the 1940-1945 period there were 5 deaths or 55.5 per cent, in the 1945-1950 interval 6 deaths or 33.3 per cent and no deaths in the 1950-1952 period.

Conclusions

1. The historical considerations, etiology, pathology, symptomatology and treat-

TABLE II
MORTALITY FOLLOWING SURGICAL INTERVENTION
FOUR CASES

CASE	AGE	CHIEF COM.	DURATION P.I.	PHYS.EXAM.	OPER. FINDINGS	OPERATION	PRE-OP. DIAGNOSIS
#22	59	Abdominal pain, nausea and vomiting 3 plus.	48 hours	BP 98/22 P 112 4 plus tenderness and rigidity, 4 plus abd. distention	Necrotic pancreatitis	Pancreas drained	Acute cholecystitis.
#29	56	Abdominal pain 4 plus	4 hours	Board-like abdomen shock	Rupt.duodenal ulcer-necrotic pancreatitis	Closure rupt. duodenal ulcer.	Ruptured duodenal ulcer.
#34	53	Abdominal pain, three plus	4 hours	4 plus gen.abd. rigidity and ten. no peristalsis.	Stone in com. duct, hemorrhagic pancreatitis.	Cholecystectomy and choledochostomy	Ruptured duodenal ulcer.
#37	73	Epigastric pain and vomiting, 4 plus.	4 hours	4 plus tenderness and rigidity. Positive Grey Turner sign.	Necrotic pancreatitis	Cholecystostomy	Perforated duodenal ulcer.

ment of acute pancreatitis have been reviewed.

2. Thirty-three patients with acute pancreatitis admitted to St. Joseph Hospital, Lexington, Kentucky in the period 1940-1952 are reported.
3. Diagnosis in this series was made by the laboratory in 26.5 per cent, surgery in 47 per cent and necropsy in 26.5 per cent. There has been an increased use of the laboratory for aid in diagnosis in more recent years.
4. Early diagnosis is stressed in an effort to avoid surgery and institute early curative conservative treatment.
5. There were 14 cases or 42.5 per cent treated conservatively and 19 cases or 57.5 per cent treated by operative intervention in this series. This would appear to indicate that cases of the acute abdomen are being surgically explored without first ruling out the condition of acute pancreatitis.
6. The mortality rate for patients having conservative treatment was 50 per cent. This is higher than generally reported. Reasons for this are discussed and the deaths analyzed. Excluding the patients moribund on admission, the corrected mortality rate was 7.1 per cent.
7. The mortality rate for patients having surgical intervention was 21.9 per cent. These deaths are analyzed.
8. 36.7 per cent of those patients undergoing surgery did so on the basis of a mistaken diagnosis with a mortality of 29.5 per cent.

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SPECIAL ARTICLES

LUNG CANCER

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Cancer of the lung statistically is increasing more rapidly than any other cancer in humans. From a medical rarity at the turn of the century it increased 144 percent from 1920 to 1948. During the same period the total deaths from cancer increased 31 percent. In 1949 twice as many patients with cancer of the lung were admitted to the Memorial Hospital in New York compared to those with gastric cancer. Ochsner estimates that if the present incidence continues that by 1970, cancer of the lung will represent 18 percent of all deaths.

Bronchogenic carcinoma predominates in men because the male endobronchial mucosa is peculiarly susceptible to malignant changes, such as epidermoid carcinoma which comprises 95 percent of the bronchogenic carcinomas in men, whereas in women with cancer of the lung it represents but 5 percent. Women are more prone to develop adenocarcinoma.

It is a sad commentary on our diagnostic acumen that there is a delay of from seven to eight months before the diagnosis is made. The average delay due to the patient's neglect of symptoms is three or four months and after the patient has consulted his physician there is another delay of five months before a definite diagnosis is established. It is axiomatic that the first prerequisite in any diagnosis is to know when to suspect it. With a progressively aging population more and more individuals are reaching the cancer stage, which is the sixth decade, for bronchogenic carcinoma in men and this is the peak. Unfortunately the onset is most insidious, and the condition is already advanced in many cases by the time a diagnosis is made so that 41 percent are inoperable at the time the lesion is recognized. Of those submitted to operation another high proportion (35 percent) are found inoperable after the chest is opened.

This gloomy picture is sufficient justification for calling the condition to the attention of the profession in the hope for earlier diagnosis. While there are no pathognomonic signs or symptoms that are infallible components of the disease, there are certain symptoms that at least ought to lead us to suspect it. The first is the age of the patient, for if he is above fifty and has respiratory symptoms he is a potential candidate for bronchogenic carcinoma, and this should always be listed in the possible categories. Cough, as would be expected, is the most frequent symptom. It loses much of its significance however, when it occurs in individuals who have had a long standing chronic bronchitis, since it is natural to assign the cough to this. It is only when the cough has become excessive that the individual seeks relief either of his own volition, or more often, at the insistance of his family. Cough occurred in 90 percent of Ochsner's series.

Pain in the chest is of the utmost significance and varies in the collected cases from 25 percent in the Hines Hospital cases to 67 percent in Ochsner's series.

Cough, pain, weakness and hemoptysis in the middle age groups call for a meticulous examination to exclude cancer. The diagnosis may be made in 82 percent of individuals with bronchogenic carcinoma by adequate x-ray studies. The roentgenological finding consists primarily of atelectasis in 63 percent of the series and of infiltration in 45 percent of the balance.

Isolated spherical densities occurring in the lung fields in non-tuberculous individuals always cause concern. Of those that have been resected 38 to 48 per cent have proved to be malignant. Even where one may be reasonably sure that the spherical density is benign, such as hamartoma, neurofibroma, caseous tubercle, or tuberculoma, its removal is thoroughly justified for the patient should be given the benefit of any doubt.

Cancer of the lung, especially the invasive type, may mimic pulmonary tuberculosis, either upper lobe or basilar lesions. The routine procedure should be physical examination, and in this connec-

tion it is worthy of emphasis that every lung that wheezes is not asthmatic or emphysematous; localized wheeze is of the utmost diagnostic significance. Every x-ray examination should be preceded by careful fluoroscopy, for the tell-tale loss of motion of one diaphragm, the possible shift of the mediastinum on forced expiration, or the evidence of obstructive emphysema speak volumes to the competent observer and will dictate the type of x-rays required to elucidate the lesion. Besides the conventional x-rays, the examiner as a result of his fluoroscopic observation may elect to take films on full expiration as well as inspiration, obliques, lordotics and others.

Sputum examinations should be made for tubercle bacilli and a fresh specimen should be collected in 70 percent alcohol and stained for cancer cells. It is my impression as well as experience that where the sputum examination is positive the case is no longer early, but not necessarily inoperable.

Bronchoscopy has been relegated to the back ground as an early diagnostic procedure, none the less every lung lesion that is suspected of being cancer should be bronchoscoped; even if no lesion is visualized, and no biopsy can be obtained. The fixation of the lung root, the compression of the bronchi from without may give the supporting evidence that is sorely needed to clarify a questionable pulmonary lesion, to say nothing of the opportunity to aspirate bronchial secretions from the pulmonary segment involved. Not infrequently the inevitable bronchostenosis, the atelectasis and at times the associated low grade infection, fever and leucocytosis all precipitated by a recent respiratory episode lead one to suspect a post viral pneumonitis and treatment is instituted with antibiotics. The subsequent clearing of the inflammatory reaction, loss of fever and partial relief of the atelectasis gives one a false sense of security and valuable time is lost. It is not infrequent for bronchogenic carcinoma to proceed to the evolution of pulmonary abscess with all the clinical symptoms of such. Since the x-ray is capable of making the diagnosis of bronchogenic carcinoma or at least of leading one to suspect it in such a high percentage of cases, it behooves those who undertake to x-ray chests to preserve their films for a reasonable length of time, so that they may be available for comparison reading. In cancer of the lung and tuberculosis they become an invaluable chronological record and date the evolution of the process, especially negative films. It has recently been suggested by Dr. Leo Riegler, that when films are to be discarded we throw away the positives and keep the negatives.

It is not unusual for all of our laboratory procedures to fail to elucidate the lesion observed in the x-ray films. In these cases it is consistent with good practice to resort to open thoracotomy and biopsy. The laity are becoming conscious of lung cancer, especially the heavy smokers and it is obligatory that the profession have an awareness of its frequency and utilize repeated chest x-rays for its detection. It has been suggested that heavy smokers above fifty years of age have x-rays made of their chest every six months.

If this be carried out it would go a long way in the detection of bronchogenic carcinoma. It must not be overlooked that mass photoflurography may play as important a role in the discovery of symptomless cancer of the lung as it plays in the discovery of pulmonary tuberculosis.

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EDITORIALS

THE INTERN MATCHING PROGRAM IN HOSPITALS NOT AFFILIATED WITH MEDICAL SCHOOLS*

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It seems appropriate at this time to consider some of the relative merits of the National Intern Matching Program from the standpoint of the smaller hospitals and the hospital not associated with a medical school, since the third year of the program is now well underway, and the fourth year is soon to be contemplated. The non-affiliated hospital is often referred to as a non-teaching hospital. This probably is the result of the practice of considering hospitals associated with medical schools as teaching hospitals, implying that non-affiliated hospitals have no teaching program. This appears to be an unfortunate impression, since many of the finest teaching programs, as far as the intern is concerned, are carried out in hospitals not associated with medical schools.

Consider the scope of teaching in the medical school affiliated hospital. There is always an extensive residency program, often special fellowships. The staff is engaged in extensive research programs, and devote a good part of their time teaching medical students and attending clinics for the purpose of teaching medical students. The intern group frequently does not get the advantages of either the medical student group or the residency group since in one case he has already had it in medical school and in the other the association with the staff comes during the residency. The intern finds himself in the role of spectator in this sort of situation. This is not the case in the non-affiliated hospital. Here the teaching program is directly for the benefit of the house staff. The intern enjoys closer association with the visiting staff, is allowed much more independence in work, and he has many more responsibilities and opportunities for independent work.

Many non-affiliated hospitals, particularly the larger ones, offer excellent residency programs. Many have on their staffs men of great medical stature and exceptional ability. Hence the medical student seeking an internship need not fear that he will not receive adequate instruction and direction if he interns in an approved hospital not affiliated with a medical school. He will also have the important advantage of receiving considerably more money for his services than he would receive in a medical school affiliated hospital.

Why is it, then, that these hospitals receive less than their relative share of interns? While it is true that in 1953 the matched interns filled only 55 per cent of the available vacancies, the major teaching hospitals filled 68 per cent of their vacancies through the matching plan, the minor teaching hospitals 44 per cent and the non-affiliated hospitals 43 per cent. A total of 808 hospitals participated in the matching plan. Of these 403 hospitals sought fewer than ten interns, and 202 of these did not receive a single intern. Perhaps it is not possible to answer why these non-affiliated hospitals do not receive their proportional share of interns, except that the present trend has been for medical school graduates to seek internships in the so-called teaching hospitals. Perhaps the trend is already beginning to swing in the opposite direction.

From the figures presented it would appear that the matching plan, with all of its so-called advantages, may be of questionable value to the non-affiliated hospital. However, it is doubtful if the non-affiliated hospitals are any worse off under the matching plan than before. It appears that most non-affiliated hospitals participate in the matching plan because there is little choice and because most medical students enroll with the plan. In most incidents the non-affiliated hospital knows well in advance what interns are expected

*This thought-provoking editorial was written at the request of the KSMA Committee on Hospitals, and does not necessarily reflect the policy of the association.

to be matched, therefore the matching plan might be said to serve only as a somewhat cumbersome method at arriving at a contract with a medical school graduate. As long as more than 50 per cent of the internships in non-affiliated hospitals remain unfilled by the matching program it seems an unnecessary waste of time and effort for the national committee to process applicants when these applicants have already indicated their desire to intern in a specific hospital and the hospital has made it known that he is acceptable. Both of these practices are permitted, it is understood, and even encouraged by the national committee.

Following the matching, the national committee frequently works a hardship on the non-affiliated hospitals by publishing a list of the number of prospective interns matched with each institution. The prospective intern may see only a small number matched with the hospitals with which he is matched and be led to the erroneous conclusion that he has made a mistake and has selected an undesirable institution. The intern may then feel he should refuse to sign a contract or have anything further to do with the institution with which he is matched.

Following the completion of the matching procedure there is always a number of graduates who are not matched. Also, some graduates do not participate in the plan. These graduates are immediately swamped with attractive offers. This has a strong tendency to reward availability rather than scholarship.

It is hoped that as the methodology of the matching plan is improved and developed, the problem of the nonaffiliated hospital will be given equal consideration with the medical school affiliates.

PROGENITOR OF KY. RURAL HEALTH MOVEMENT TRANSMITS RECORD OF PROGRESS TO SUCCESSOR

With the change in chairmen of the Kentucky Rural Health Council, made at the suggestion of the retiring chairman, Walter L. O'Nan, M.D., Henderson, it is appropriate that an inventory be taken of work done so far by this organization which was created by the Kentucky State Medical Association.

While the Rural Health Council Movement, futherance of which is the primary objective of the Kentucky Rural Health Council, must still be regarded as in its infancy, a noteworthy beginning has been made which bodes well for citizen participation at the local level in Kentucky's continued health progress.

The Kentucky Rural Health Council was founded late in 1951 by the Kentucky State Medical Association with specific leadership being provided by the KSMA Rural Health Committee under the chairmanship of Doctor O'Nan. Its membership consists of state-wide organizations interested in rural health problems. The number of such participants has now grown to include 18 different groups.

In May, 1952, the first Kentucky Rural Health Conference was held in Louisville. Similar conferences have since been held in March of 1953 and 1954. Since the first conference served as the "kick-off" for the Kentucky Rural Health Council Movement, it can be seen that the activity is now less than two years old. The extent to which the people have taken to the idea of local rural health councils—based on the principle of voluntary cooperation—is indicated by the increased emphasis in the 1953 and 1954 conferences on reports from groups that are really doing a job at the local community level.

The idea that laymen themselves, through cooperating and counseling together, can alter their communities for better health and better living has taken a good foothold. There are now enough examples of the idea's success in Kentucky to show that the Rural Health Council Movement is no fly-by-night affair. The work of the KSMA Rural Health Committee under the leadership of Dr. O'Nan has been important in this record of progress. Support of rural health councils by county medical societies and individual physicians has been an equally essential ingredient to success at the local level.

It may be expected, on the basis of the fine assistance rendered Dr. O'Nan by Wyatt Norvell, M.D., New Castle, as chairman since October of the KSMA Rural Health Committee, that the fine work of the Rural Health Council will continue as Dr. Norvell succeeds Dr. O'Nan to the chairmanship of that body.

President's Page

Guest Contribution

A recent meeting held in Indianapolis, concerning V.A. medical care, deserves the attention of all physicians in Kentucky. A number of meetings of this kind have been held by members of the A.M.A. in different sections of the country. Representatives from the K.S.M.A. as well as representatives from Illinois, Indiana, Michigan, Ohio and Wisconsin were present.

Some time ago, a "Fact Book on V.A. Medical Care" was received by all of us. I wonder how many of us have read it. It is quite informative and is certainly worth the time it takes to peruse it. From the few words I can give you here and from more detailed reports you may read, I would urge you to consider its importance to all of us, now, and in the future as far as government medicine is concerned.

Many of us may or may not agree entirely with the A.M.A. policy. However, all of the representatives at the meeting agreed in principle, even though the policy may have to be more flexible in certain communities. Since 1934, no basic change has been made in the law, but over thirty diseases have been added under which veterans can qualify.

The veteran population in 1924 was five million, in 1953 over twenty million. This increases every year from three to four hundred thousand. Forty per cent of the male adult population are veterans. The majority of these are World War II and Korean veterans, and as they grow older, the percentage of medical care will naturally increase. The number of veteran hospital beds in 1924 was 15,798 and in 1953, 118,238. If the present trend continues, it is estimated that by 1975 approximately 400,000 beds will be needed.

There are sufficient beds now for service connected disability cases and no one wishes to deny them the privileges to the best medical care. The A.M.A. does not question the care of service connected disabilities, tuberculosis or mental conditions.

Non-service connected cases in V.A. hospitals make up more than eighty four per cent of patients treated according to statistics in 1951. Cost of V.A. care has skyrocketed from $37,000,000 in 1934 to $730,000,000 in 1953. These few notes are just food for thought as well as action on our part.

Let us contact our senators and representatives regarding this situation, educate our patients as well as ourselves through talks at our societies, secure information through society bulletins and journals and create good public relations through our press by formation of liaison committees with veteran organizations in each state or county. Remember that our own organization in cooperation with other groups is the key to success or failure in this very important milestone in medicine and in the future of medicine.

Robertson O. Joplin, M. D.
Vice-President, Central Kentucky

* * *

We have passed the half-way mark for the 1953-54 year of the Kentucky State Medical Association. Many of the committees have been quite active. Others have had very little to do. This is to call to the attention of the latter group the hope expressed at the beginning of the year, that each committee would have at least one meeting.

Even if no problem has been referred to it, a discussion of its function can be held and worth while suggestions can be offered. It is not too early for the various chairmen to call such meetings and they are reminded that the Headquarters Office is ready at all times to do the necessary clerical work. Many thanks for your cooperation in this matter.

J. Duffy Hancock
President

ORGANIZATION SECTION

Drs. Parks and Wall to Be Highlighted on Scientific Program at Annual Meeting

Innovation to Permit Increased Number of KSMA Members To Participate

John Parks, M.D., Washington, D. C., and James H. Wall, M.D., New York, are among the top flight visiting essayists who will present papers at the 1954 Scientific Assembly of the Kentucky State Medical Association, September 21, 22, and 23, at the Columbia Auditorium.



Dr. Wall

Dr. Parks, who is the choice of the Kentucky Obstetrical and Gynecologic Society will discuss "Obstetric Misconceptions" before the general session and "Operative Obstetrics" at the meeting of the OB-GYN specialty group Wednesday afternoon, when the eight specialty organizations will hold programs simultaneously.

"Emotional Disorders Commonly Met in General Practice" will be considered by Dr. Wall in his talk before the general session. When speaking before men who limit their practice to psychiatry, he is expected to discuss "Hospital Treatment of Long Term Psychiatric Problems." Dr. Wall will be the special guest of the Kentucky Psychiatric Association.

"The Committee on Scientific Assembly is well pleased with the enthusiasm the committee's announcement received relative to the specialty group program plans for Wednesday afternoon, September 22, during the meeting," J. Duffy Hancock, M.D., Louisville, chairman, indicated as he discussed plans for the outstanding program his committee is planning.

"Some 18 or 20 more KSMA members than is usually customary will participate in the Annual Meeting Program under the special Wednesday afternoon arrangement," Dr. Hancock pointed out. Each of the eight groups will sponsor its own program Wednesday afternoon which will include three KSMA members and a guest speaker.



Dr. Parks

Dr. Parks has served as the Professor of Obstetrics and Gynecology at the School of Medicine of George Washington University since 1944. Before his present assignment, Dr. Parks, who is a member of the Board of Directors of the American Board of Obstetrics and Gynecology, was Chief Medical Officer in Obstetrics at Gallinger Municipal Hospital from 1938 to 1944. He received his medical degree from the University of Wisconsin in 1934.

A native of South Carolina, Dr. Wall was graduated from the Jefferson Medical College of Philadelphia in 1927. Dr. Wall is currently serving as Associate Professor of Clinical Psychiatry of Cornell University Medical College and as Medical Director of the New York Hospital, Westchester Division. He is a staff consultant on a number of other general hospitals in the Westchester County area.

Legislature Enacts Proposals Endorsed by KSMA

By B. B. Baughman, M.D., Chairman
KSMA Legislative Committee

The 1954 session of the Kentucky General Assembly, which came to a close March 19, considered more than 30 bills which would have affected adversely or favorably the medical profession and the health of the people it serves, and adopted several proposals which had the endorsement of the Kentucky State Medical Association.

Prominent among the measures enacted into law were proposals relating to tuberculosis control, rabies control, the Rural Kentucky Medical Scholarship Fund, creation of a board of ophthalmic dispensers, regulation of the practice of optometry, and liberalization of statutes governing chiropody, all of which had, as passed, the support of the medical profession.

The tuberculosis control measure, which passed the House by a vote of 55-20 and the Senate 29-0, requires that persons with communicable tuberculosis take certain precau-

tions and allows confinement of such persons who fail to take such precautions. The rabies control bill, which also contains provisions for control of stray doys, requires licensing of all dogs and compulsory vaccination. It passed the House by a vote of 55-32 and the Senate, 22-7.

The Rural Kentucky Medical Scholarship Fund was voted, without dissent, an annual appropriation of $5,000 for the next two years, the funds to be made available through the State Department of Health. This measure was introduced at the request of the Scholarship Fund trustees under the chairmanship of C. C. Howard, M.D., Glasgow, in order to enable the fund to avoid curtailment during the next several years of loans to medical students agreeing to practice in selected rural Kentucky counties.

The chiropody bill created an independent board of chiropody. The ophthalmic dispensers bill, which was jointly introduced by B. F. Shields, M.D., Shelby County, and J. E. Johnson, M.D., Pike County, both members of the Senate, created a board of ophthalmic dispensers and regulation for ophthalmic dispensing. The optometry bill, which received a number of amendments before final passage, related to the regulation and licensing of optometrists and regulation of advertising of optometrical supplies.

Other bills which passed included an amendment to the statutes to enable city universities to spend proceeds of bond issues for their law, medical and dental schools; provision that a prescribed per cent of alcohol in the defendant's blood shall give rise to a presumption of guilt in drunken driving cases; amendment to the statutes to put coroners on monthly compensation; designation of the county health officer or administrator as registrar of vital statistics; amendment of the statutes to establish tuberculosis districts and redesignating the Tuberculosis Sanatoria Commission as the State Tuberculosis Hospital Commission; amendment of the statutes transferring to the Department of Health those functions of the State Board of Health which are administrative in nature and clarifying other statutory provisions, and amendment of the statutes to define certain synthetic habit-forming drugs as narcotics and repealing certain conflicting sections of the Narcotic Act regarding marijuana.

Among the bills which failed of passage were proposals to establish a Kentucky Alcoholism Commission; to direct the Legislative Research Commission to study the desirability of creating a medical school and medical center in Northern Kentucky; to authorize a qualified person to formulate plans for the establishment of a medical school at the University of Kentucky; to provide for creation of a State Department of the Handicapped and transferring all property, funds and facilities of the Crippled Children's Commission to such a department, and to amend the statutes to extend to July 1, 1956, the period during which the practical nurses can be licensed without meeting the now prescribed standards.

As is not unusual, some of the most undesirable proposals were incorporated into bills the primary purpose of which covered matters not of primary interest to the medical profession. The Legislative Committee detected several such "sleepers," none of which were enacted into law.

Dr. Hancock to Preside at Silver Jubilee of Surgical Congress

J. Duffy Hancock, M.D., Louisville, KSMA president, who was installed as 1954 president of the Southeastern Surgical Congress which met March 8-11, in Birmingham, Alabama, will preside next year over the Silver Jubilee Assembly, scheduled to begin early in March, 1955, at Atlanta, Georgia.

Clyde C. Sparks, M.D., Ashland, president-elect of the KSMA, was appointed to succeed Dr. Hancock as Councilor from Kentucky for the Southeastern Surgical Congress. He will serve a five-year term.

A record breaking attendance of over 1000 were present at the 22nd Annual Spring Assembly held at the Dinkler-Tutwiler Hotel. Fifty two scientific papers were presented by outstanding speakers from all over the nation.

Other officers of the Congress are Donald S. Daniel, M.D., Richmond, Virginia, the new president-elect, and B. T. Beasley, M.D., Atlanta, Georgia, secretary.

Two KSMA surgeons, John T. Bate, M.D., and Franklin Jelsma, M.D., both of Louisville, participated in the scientific program. Dr. Hancock was elected president by the Congress, composed of representatives from 12 states during the 21st Annual Meeting in March, 1953, which was held at the Brown Hotel, Louisville.

Classes to Reunite in September

One of the highlights of the Annual Meeting of the Kentucky State Medical Association, to be held in Louisville, September 21, 22 and 23, will be the class reunions of 1914, 1924, 1934, and 1944 graduates of the University of Louisville School of Medicine. According to Leslie Shively, director of Alumni Relations for the University of Louisville, good turnouts are expected for all class reunions this year.

TV Viewers to See AMA Session In San Francisco, June 24

A special nation-wide television report originating from the scene of the Annual Meeting of the American Medical Association in San Francisco will be presented June 24, as the third program in the 'March of Medicine' spring series.

Sponsored by Smith, Kline and French Laboratories in cooperation with the AMA, eleven programs have been carried over 78 stations of the NBC television network since the inception of the series in June 1952.

The last program telecast in April was designed to bring a nationwide audience a glimpse into current research on the problem of arthritis and rheumatism. Other subjects which have been presented include heart disease, cancer, the AMA Clinical Session, and overweight.

Pediatric Postgraduate Program Features 32 Speakers

Thirty two scientific speakers will address or hold clinical conferences at eight sessions of the Pediatric Postgraduate Course, sponsored by the University of Louisville School of Medicine, the American Academy of Pediatrics, and the Kentucky State Medical Association, beginning May 6, 1954, and continuing through June 24.

The weekly sessions to be held at Children's Hospital, Louisville, will run for three consecutive hours beginning at 9:30 a. m. until 12:30 p. m. each day, according to W. W. Nicholson, M.D., Louisville.

All attending members of the American Academy of Pediatrics will be given credit for the course, Dr. Nicholson said. A program of the Pediatric Course will be mailed to physicians who reside within the general area of the meeting.

Dr. Marshall Elected President of OB-GYN Society

Jennings B. Marshall, M.D., Louisville, 1953-54 vice-president, was elected president of the Kentucky Obstetrical and Gynecologic Society during the seventh Annual Meeting in Frankfort, April 2-3, according to Leon Higdon, M.D., Paducah, retiring president.

Other officers elected were Arthur B. Barrett, M.D., Lexington, vice-president, and Robert C. Bateman, M.D., Danville, secretary-treasurer, Dr. Higdon stated.

The following physicians were selected to serve on the Executive Committee: Erwin G. Heiselman, M.D., Newport; Joseph H. Liebman, M.D., Frankfort, and Robert A. Orr, M.D., Mayfield. Dr. Liebman also served as Chairman of Entertainment and Arrangements for the meeting.

According to George McClure, M.D., Danville, retiring secretary, 65 physicians registered for the OB-GYN annual meeting, and 18 new physicians were granted membership in the society.

June Meeting in Frankfort Will Be Held by 7th District

A scientific program featuring local members and an out-of-state guest speaker will highlight the program of the Seventh Councilor District of the KSMA at Frankfort early in June.

According to Councilor B. B. Baughman, M.D., Frankfort, the annual dinner meeting will be held at the Frankfort Country Club with the Franklin County Society acting as the host group.

Wives are cordially invited to attend the meeting, Dr. Baughman said. He also explained that detailed information would be sent to each member of his district at an early date preceding the meeting.

Technical Exhibitors Rent 61 Spaces in One Week

Space in the Technical Exhibit Hall at the 1954 Annual Meeting, September 21, 22 and 23, in the Columbia Auditorium was absorbed the first week it was offered as has been the case in the past, announced Carlisle Petty, M.D., chairman of the KSMA Committee on Technical Exhibits.

"Three new companies will be seen in the hall this fall, since three of our patrons have withdrawn from business in this area. The new companies to take their places have been on the waiting list for some time," Dr. Petty said. "A total of 61 companies will exhibit this fall."

"The high degree of cooperation shown by KSMA members with the Technical Exhibitors at our Annual Meeting is fast making our annual session a standout meeting among the groups who service our profession and who sponsor technical exhibits at medical meetings the country over," the chairman stated.

Members were urged to plan to visit each exhibit at the 1954 meeting, not only because

of the fact that rentals from the exhibits finance the cost of the meeting, but mainly because of the valuable and practicable contribution the technical exhibitor is able to make to the modern practitioner, Dr. Petty pointed out.

Foundation Planned to Promote New Medical School

A committee of seven including three Lexington physicians met March 13 to discuss plans for the creation of the Kentucky Medical Sciences Development Foundation to administer a program which would promote establishment of a medical school at the University of Kentucky, estimated at a cost of $25,000,000.

Francis M. Massie, M.D., chairman of the Medical-Education Committee of the Fayette County Medical Society, John S. Chambers, M.D., head physician at the University, and Coleman Johnston, M.D., are the physician-members of the committee.

One of the functions of the foundation will be to receive tax-exempt funds from private sources, to be used to match public funds for the project, the physicians said. Plans were discussed for the appointment of a board of directors for the foundation to consist of about 50 persons chosen from interested citizens from all areas of the state.

Ky's Fully Accredited Hospitals Total 21, Report Shows

According to its first annual report released by the Joint Commission on Accreditation of Hospitals, directed by Edwin L. Crosby, M.D., Chicago, Kentucky has 21 fully accredited hospitals and 11 provisionally accredited ones. The Commission gave full accreditation to 2,920 hospitals and provisional accreditation to 498, a total of 3,418; there are about 7,500 hospitals.

"Before a hospital is surveyed for accreditation, the hospital must itself request such action," Dr. Crosby said. "Hospitals under 25 beds are not eligible for accreditation." He pointed out that it had not been possible to visit all hospitals which requested accreditation during the year.

There is no charge to the hospital for the Commission's service, the cost being borne by the participating organizations, the AMA, the American College of Physicians, the American College of Surgeons, and the American and Canadian Hospital Associations. The program costs about $500,000 annually.

"A certificate of accreditation given to a hospital proves that it has voluntarily met the standards of the Commission which are designed to insure the public of the best possible hospital care. It means that the hospital is a safe place, and that the medical staff itself reviews the work of its members to guarantee that the patients are getting good care."

The fully accredited hospitals in Kentucky are listed by location as follows:

Ashland: King's Daughters' Hospital,

Berea: Berea College Hospital,

Bowling Green: Bowling Green - Warren County Hospital,

Covington: St. Elizabeth Hospital, William Booth Memorial Hospital,

Hopkinsville: Jennie Stuart Memorial Hospital,

Lexington: Good Samaritan Hospital, Julius Marks Sanatorium, St. Joseph Hospital, Shriners' Hospital for Crippled Children,

Louisville: Children's Hospital, Kentucky Baptist Hospital, Louisville General Hospital, Kosair Crippled Children Hospital, Norton Memorial Infirmary, Red Cross Hospital, St. Anthony Hospital, St. Joseph Infirmary, SS. Mary and Elizabeth Hospital,

Paducah: Riverside Hospital,

Waverly Hills: Waverly Hills Tuberculosis Sanatorium.

Provisionally accredited hospitals in Kentucky, listed by location, are as follows:

Dayton: Speers Memorial Hospital,

Frankfort: King's Daughters' Hospital,

Glasgow: T. J. Samson Community Hospital,

Greenville: Muhlenberg Community Hospital,

Henderson: Methodist Hospital,

Louisville: District Two State Tuberculosis Hospital, Jewish Hospital,

Lynch: Notre Dame Hospital,

Maysville: Hayswood Hospital,

Owensboro: Owensboro-Daviess County Hospital,

Somerset: Somerset City Hospital.

Varied Auxiliary Projects Include Cancer and Nursing Emphasis

Among the many activities sponsored this year by the Woman's Auxiliary to the KSMA has been an essay contest on the subject of "Cancer," for high school students, which this year was won by a girl from Garth High School in Scott County, according to Mrs. Clyde C. Sparks, Ashland, auxiliary president. Thirty-six contestants throughout the state entered essays.

Another state-wide project sponsored by the auxiliary has been promoting interest in the nursing profession through establishment of Future Nurses' Clubs. Two have been established in Daviess and Fayette County and organizational plans are underway for others. Interest in nursing is also being encouraged in McCracken and Warren Counties through the Senior Girl Scouts who teach courses in Red Cross Home Nursing and serve as hospital aides.

The Carroll-Trimble-Gallatin Auxiliary is leading the nation in the subscription contest to Today's Health Magazine, which is a special effort on the part of the auxiliary to increase subscriptions among lay people as well as those in direct contact with the medical profession, Mrs. Sparks said. She also added that the auxiliary has increased its membership by 132 this year, reaching a total of 905.

KSDA Names Dr. John Atkinson Pres-Elect, April 6

John A. Atkinson, D.D.S., Louisville orthodontist and faculty member of the University of Louisville Dental School, was named president-elect of the Kentucky State Dental Association at the Annual Meeting in Louisville, April 4-7, 1954.

E. A. Willis, D.D.S., Owensboro, long active in dental organization affairs was installed as 1954-55 president at the Annual Banquet, April 6, Kentucky Hotel. A. B. Coxwell, D.M.D., Louisville, was re-elected secretary-treasurer.

"Oral Lesions in Hematology" was discussed by Marion F. Beard, M.D., F.A.C.P., Louisville, KSMA member who appeared as a featured guest speaker. Bruce Underwood, M.D., Louisville, brought greetings as the State Commissioner of Health.

Nursing Aide Project Developed For Kentucky Hospitals

The Kentucky League for Nursing in cooperation with other state groups has assumed leadership in initiating the Nursing Aide Project in Kentucky, designed to help hospitals develop an in-service training program for auxiliary nursing personnel, according to Miss Kathryn B. Ernstes, Louisville, president of the league.

Under the program, nurses will be selected by state committees to attend regional teacher-training institutes sponsored by the Department of Hospital Nursing of the National League of Nursing. Following participation they will return to their states and initiate local workshops for nurse instructors from Kentucky hospitals.

Miss Ernstes stated that the purpose of the program is not to create a new group of workers to prepare persons for licensure, but to furnish necessary initial or additional training for nursing aides, orderlies, attendants, who have not received adequate training in the fundamentals of nursing. She expressed the hope that hospitals throughout the state would agree on the importance of participation in the project, and cooperate in carrying out the program.

District 2 Hears Doctor Guker March 23, Owensboro

Thomas Guker, M.D., nationally-known physician from Warm Springs, Georgia, addressed the annual dinner meeting of the Second Councilor District, Owensboro, March 23, with a timely subject, "What Can We do About Polio Now?" The speaker's talk was well received and provoked a thorough and careful discussion among the 60 attending members.

District Councilor Walter L. O'Nan, M.D., Henderson, announced the election of George A. Buckmaster, M.D., Henderson, as the new president, succeeding James E. Hix, M.D., Owensboro. Darrel L. Vaughn, M.D., Henderson, was appointed secretary by the new president.

Also on the program was J. Duffy Hancock, M.D., Louisville, president of the KSMA. The members of the Daviess County Medical Society served as the host group, Dr. O'Nan stated.

Procedure Given for Admission of Patients to VA Hospital

At the last meeting of the House of Delegates, the Journal of the KSMA was authorized to carry information relative to the procedure of admitting patients to the Veterans Administration Hospital.

The KSMA Veterans Committee, Daniel L. Bower, M.D., Barbourville, chairman, has obtained the following official information from the office of R. R. Kaplan, M.D., chief of professional services.

"Any veteran under the care of a private physician considered in need of hospitalization should be referred to the admitting physician of the Veterans Administration Hospital, Louisville, by a telephone call from the private doctor. This call may have the charges reversed.

"The private physician should be prepared



Clarence Miller, Shelbyville, member of the Rural Kentucky Medical Scholarship Board of Trustees and the Kentucky Farm Bureau Federation, describes the operation of the Scholarship Fund at the Annual Dinner during the Third Rural Health Conference in Louisville, March 10-11. At present, Mr. Miller is state chairman of the Agricultural, Stabilization and Conservation Administration, a federal agency.

to discuss (1) the patient's immediate medical condition and reason for requesting hospitalization, (2) length of time under his care, (3) type of medical treatment the patient has been receiving, (4) mode of transportation required to get to the hospital, and (5) whether the patient or his family state he is able to pay for his own transportation to the hospital. Emphasis is placed on the last question because neither the ambulance company nor the veteran can be reimbursed unless prior authorization for travel has been granted by the VA.

"Any diagnostic work completed by the private physician, such as X-Rays, laboratory results, etc., would be helpful to the examining physician in the Admission Office and should accompany the patient. Upon completion of a physical examination by the VA physician, the patient's admission to the hospital will be determined by two factors: (1) whether the nature of his illness or injury requires hospitalization and, (2) the availability of a bed."

Physicians Urged to Join New Ky. Trudeau Society, May 28

Physicians are invited to join the Kentucky Trudeau Society which will be organized May 28, at the Seelbach Hotel, Louisville, according to the Kentucky Tuberculosis Association

Robert J. Dancey, M.D., Madisonville, has been named temporary chairman by thirty Kentucky physicians who have petitioned for recognition of the Kentucky unit. He stresses that membership in the American Trudeau Society is not a requisite for membership in the Kentucky Society.

The purpose of the society is to promote medical research and education on diseases of the chest among practicing physicians and medical students. It will function as a branch of the Kentucky Tuberculosis Association and act as an advisor on medical matters pertaining to tuberculosis and other pulmonary diseases. Further information is available from the Kentucky TB Association, 1480 S. Third Street, Louisville, Kentucky.

Muldraugh Hill Program Includes Luncheon and 8 Speakers

A meeting, which included a luncheon session, of the Muldraugh Hill Medical Society was held April 8, at Hardin Memorial Hospital, Elizabethtown, according to Joseph C. Ray, M.D., Louisville, secretary.

At the morning session the following papers were presented: "Diseases of the Breast," by Lanier Lukins, M.D., Louisville; "Recent Advances in the Treatment of Pernicious Anemia," by Captain Donald R. Lyon, M.C.; "Blood Transfusions," by E. H. Sanneman, M.D., Louisville; "The Report of the Veterans Committee of the State Medical Association," by Robertson O. Joplin, M.D., Louisville.

On the afternoon program "Everyday Practi-

cal Proctology" was discussed by Marvin A. Lucas, M.D., Louisville; "Toxicology of a New Insecticide-Parathion" by Captain Elston I. Belknap, Jr., M.C.; "Obstruction to the Airway" by Captain Fred G. Arragg, M.C., and a case report was given by Lyman S. Hall, M.D., Campbellsville.

KSMA Physicians Participate in College of Surgeons Meeting

Three KSMA members, K. Armand Fischer, M.D., R. Arnold Griswold, M.D., and Rudolph Noer, M.D., all of Louisville, participated in the program of a Sectional Meeting of the American College of Surgeons at French Lick, Indiana, March 15-17.

According to James C. Drye, M.D., Louisville, secretary-treasurer of the Kentucky Chapter, which was organized last fall, about 75 physicians from this state attended. Total attendance was approximately 500. Dr. Fischer served as collaborator on one of the panel discussions over which Dr. Griswold presided and Dr. Noer showed a medical motion picture.

The next meeting of the Kentucky Chapter of the American College of Surgeons will be held Monday, September 20, in Louisville, directly preceding the Annual Meeting of the KSMA, September 21, 22 and 23, with Joseph Henry, M.D., Louisville, president, presiding.

District 14 Meets April 7

Fifty-two attending members of the Fourteenth Councilor District heard three scientific speakers and the president of the Kentucky State Medical Association, J Duffy Hancock, M.D., Louisville, at the dinner session held April 7, at the Prestonsburg Graded School Auditorium.

According to John G. Archer, M.D., Prestonsburg, district councilor, Foster Coleman, M. D., John Larson, M.D., Robert Long, M.D., all of Louisville, presented papers on the scientific program at the afternoon and evening sessions.

District 13 Holds Ashland Session

An all-day scientific session including a symposium, outstanding KSMA speakers, and a dinner meeting with a presidential address by J. Duffy Hancock, M.D., Louisville, was held by the Thirteenth Councilor District at Ashland, April 8, 1954, according to Charles B. Johnson, M.D., Russell, councilor.

Featured speaker at the morning session was W. Duane Jones, supervising physician on the staff of District Four State Tuberculosis Hospital, Ashland. He was assisted by members of his staff. Other scientific speakers of the day included R. Arnold Griswold, M. D., Rudy J. Noer, M.D., and George W. Pedigo, M.D., all of Louisville.

J. Ray Ingram, Louisville, assistant director, Kentucky Physicians Mutual, Inc., discussed "Improper Blue Cross-Blue Shield Utilization," at the evening dinner session, attended by 70 physicians and their wives.

Med School Applications Decrease

The number of applicants for admission to medical schools has decreased for the fourth consecutive year, although approved medical schools are now accepting their freshman classes which total almost 7500 students, an article in the Journal of Medical Education pointed out.

There are still more individuals seeking admission to medical schools than can be accepted, but the freshman class of 1953-54 had some 2,085 fewer applicants than during the previous year. It is estimated that almost 10,000 fewer individuals are making application now than did in 1949-50 when the GI bill was in full force.

Education Funds Receive Millions

For the first time since its establishment, contributions to the American Medical Education Foundation, founded by the AMA, passed the million dollar mark December 31, 1953, with a record breaking gross return totaling $1,089,962.93 received from 18,176 individual physicians, organizations and laymen.

George F. Lull, M.D., who made the announcement in his "Secretary's Letter," also reported that the Foundation's cooperating agency, the National Fund for Medical Education, which seeks its funds primarily from business and industry, had received a total of $1,367,979, representing contributions from 994 corporations. The two fund-raising organizations jointly have distributed $5,000,000 to the nation's medical schools since 1951.

VA Releases Report for 1953

The average daily patient load of veterans in VA and non-VA hospitals in 1953 was 104,482, remaining about the same as the preceding year, according to the Veterans Administration annual report.

Admissions to hospitals came to 468,349, about 27,000 fewer than in the fiscal year 1952. Most popular residency programs at VA hospitals were in internal medicine, general surgery and psychiatry, the report showed.

Committee Requests Film Subjects

Members of the KSMA are invited to participate in planning the scientific movie program for the Annual Meeting in Louisville, September 21, 22 and 23, by submitting titles of films to the Committee on Medical Education, according to Lawrence T. Minish, Jr., M.D., Louisville, chairman.

Dr. Minish suggests that a brief description of the film and its subject matter would aid the Committee in the selection and arrangement of the program. Responses to this invitation should be sent to Dr. Minish, chairman of the Committee on Medical Education, 620 South Third Street, Louisville, Kentucky.

Dr. Tyler Receives 50-Yr. Medal

A standing ovation was given W. L. Tyler, M.D., Owensboro, when he was presented the Daviess County Medical Society's "Fifty Year Medal," by D. H. Warren, M.D., society president, at the annual dinner meeting of the Second Councilor District, March 23, in Owensboro.

Dr. Tyler received his medical degree from the Hospital College of Medicine, Louisville, in 1904. He has practiced exclusively in Daviess County since the beginning of his professional career.

Blue Cross-Shield to Advertise

A national and state-wide advertising program for public education is currently being undertaken through the combined efforts of Blue Cross and Blue Shield to teach members the real value of their plans, and to promote growth of the plans. There will be a tie-in local program through Kentucky newspapers.

On the national scene, ads will be run in "Life Magazine" May 3, in "Look Magazine" May 18, and the "Saturday Evening Post" on May 22. Blue Cross and Blue Shield messages were also carried in these publications during the month of April.

Information on Gamma Globulin

The allocation of gamma globulin in Kentucky is directly dependent upon the number of cases of poliomyelitis, measles and/or hepatitis that are reported to the local health department, according to B. M. Drake, M.D., Deputy Commissioner of Preventive Medical Services, Kentucky State Department of Health. All physicians are urged to promptly report their cases, Dr. Drake said.

Rural Medical Fund Given $3,200

A contribution of $3,200 was made by the Green River Rural Electric Cooperative Corporation, Owensboro, March 1, 1954, to the Rural Kentucky Medical Scholarship Fund, C. C. Howard, M.D., Glasgow, chairman of the Board of Trustees, recently announced. The generous donation will be used to underwrite a four year scholarship for a rural medical student, Dr. Howard said.

1st District Hears Dr. Hancock

J. Duffy Hancock, M.D., Louisville, president of the Kentucky State Medical Association, was one of the featured speakers at the annual joint meeting of the First Councilor District of the KSMA and the McCracken County Medical Society, April 28, at the Ritz Hotel, in Paducah.

Sharing the program with Dr. Hancock was David Woolfolk Barrow, M.D., Lexington. Warren K. Sloan, M.D., Paducah, president of the McCracken County Medical Society, presided over the dinner meeting.

District 6 Has 'Heart' Program

J. Ray Bryant, M.D., associate professor in thoracic surgery at the University of Louisville School of Medicine, and Morris M. Weiss, M.D., Louisville, associate professor of medicine, were the featured speakers on the scientific program of the Sixth Councilor District, which met April 13, 1954, at the Franklin Country Club.

According to Richard F. Grise, M.D., Bowling Green, councilor, the scientific program was presented under the auspices of the Kentucky Heart Association. "Surgical Treatment of Heart Disease" was discussed by Dr. Bryant and "Syncope" was the topic of Dr. Weiss' talk.

KSMA Welcomes 13 New Members

The Kentucky State Medical Association recently welcomed 13 new members to membership:

B. N. Carle, M.D., Paducah;
James C. Embry, Jr., M.D., Kevil;
Frederick F. Ferguson, M.D., Madisonville;
Samuel L. French, M.D., Paducah;
Rex Holland, M.D., Paducah;
P. R. Kleykamp, M.D., Ashland;
E. Q. Parr, M.D., Berea;
William C. Roland, M.D., Pikeville;
T. E. Ruff, M.D., Paducah;
M. R. Shaw, M.D., Henderson;
Joe B. Spaulding, M.D., Paducah;
Winfield Stryker, M.D., Paducah;
Charles L. Tuttle, M.D., Murray.

Washington News Digest

Washington, D. C.—These spring days are growing into weeks that really count in Congress. Unless a bill deals with an emergency, it had better be well on its way through committees by now or its chances of enactment will fade rapidly as summer approaches.

For good or evil, a large amount of health legislation is well advanced, and if Congress holds to an average pace several bills affecting the medical profession are likely to become law in the next month or so. Here is the situation in brief:

Medical Deductions

Legislation to increase the amount deducted from taxable income for medical expenses is a part of the omnibus tax revision bill which cleared the House early and by a wide margin, but ran into some delay on the Senate side. This bill, with the medical deduction liberalization intact, should reach the White House in plenty of time.

Hill-Burton Expansion

A move to make important changes in this bill developed in the Senate Labor and Welfare Committee, after the House had passed its version with some amendments. American Hospital Association proposed that the rather complicated House legislation be scrapped, and instead that the Hill-Burton Act be amended to (a) include rehabilitation centers and nursing homes, and (b) place a high priority on hospitals for the chronically ill. The AHA idea immediately attracted support in and out of the committee. The new approach suggested by AHA meant inevitable, but probably not fatal, delays.

Reinsurance

This proposal, once hailed as the keystone of the Eisenhower administration's health program, continued to encounter opposition. At one stage, of all the national associations to testify on reinsurance only American Hospital Association was giving it unqualified support. American Medical Association, the U. S. Chamber of Commerce, and national spokesmen for the insurance industry took about the same position: 1. Reinsurance alone cannot make uninsurable risks insurable. 2. The threat of federal control of medicine is inherent in any program that would bring the federal government in such close contact with medical practice. Dr. David B. Allman, representing the AMA at the House hearings, emphasized that the Association would welcome and cooperate in any movement carrying real promise of promoting voluntary health insurance.

Health Grants

This is an administration plan to do away with the present categorical grants for identified projects, such as venereal disease control, and to substitute funds earmarked for three general purposes, (a) to maintain present programs, (b) to initiate new programs or to expand existing ones, and (c) to finance public or private experimental or pilot programs of national or regional significance. In both committees the question was whether to group the first and second type grants together, with the state health authorities deciding how to divide up the federal money among old and new projects. Funds for the third type grant—experimental—would be completely controlled by the surgeon general. One suggestion is to require approval of the state health officer for any experimental (type three) grant in his state. Another is to eliminate the third type grants altogether, letting the National Institutes of Health handle public health as well as other medical research grants.

Social Security

American Medical Association, American Dental Association and a number of other national groups are fighting vigorously to prevent compulsory extension of Old Age Survivors Insurance to physicians, dentists and most other self-employed. Instead, they want the privilege of deferring income tax payments on that part of earnings placed in restricted annuities—the Jenkins-Keogh plan. AMA also feels that there is no need for the bill's provision that pension rights be frozen during periods when the worker has been medically determined to be disabled. A better suggestion, the Association maintains, is to base pension rates on the ten best working years, thus virtually eliminating the need for the controversial medical examinations. Prospects are good that social security will be extended, either with or without these changes.

Vocational Rehabilitation

Generally, Senate witnesses favor the administration's proposal to expand the federal-state programs, providing U.S. grants aren't cut. However, with no House bill introduced as of this writing, there is some doubt that, even if the Senate clears the measure, the House can find time to deal with it.

(Continued on page 381)

News Items

James F. Halley, M.D., formerly of Memphis, Tennessee, recently associated with **William McDaniel Ewing, M.D.,** in Louisville for the practice of orthopedic surgery. Dr. Halley received his medical degree from the University of Arkansas School of Medicine in 1943 and interned at Indianapolis General Hospital. He completed a surgical residency at University Hospital, Little Rock, Arkansas, and received additional training in orthopedics at Shreveport Charity Hospital, Shreveport, Louisiana.

Sidney P. Edds, M.D., recently located in Burnside, Pulaski County, taking over the practice of **Charles P. Salyer, M.D.,** who moved to Houston, Texas, earlier in the year. Dr. Edds is a 1951 graduate of the University of Tennessee College of Medicine and interned at Knoxville General Hospital.

S. Stephen Chapman, M.D., Instructor in the Department of Bacteriology and Immunology at the Harvard Medical School, has been appointed Associate Professor of Microbiology in the Department of Microbiology at the University of Louisville School of Medicine, effective July 1, 1954. The announcement was made by James A. Kennedy, Secretary of the Medical Council.

John T. Giannini, M.D., recently located in Louisville after returning to Kentucky from out of the state. He will specialize in plastic surgery. Dr. Giannini was graduated from the University of Louisville School of Medicine in 1938 and practiced for a while at Kenvir in Harlan County.

William C. Ellis, M.D., recently opened an office in the Doctor's Building, Lexington, for the practice of obstetrics and gynecology. Dr. Ellis received his degree from the Cincinnati College of Medicine in 1949 and interned at Charity Hospital, New Orleans. He completed a three year residency in obstetrics and gynecology at Confederate Memorial Hospital in Shreveport, Louisiana.

Michael S. Zeman, M.D., formerly of Hartford, Connecticut, recently took over the practice of **Karl N. Victor, M. D.,** Louisville, who died March 9, 1954. He was graduated from the University of Louisville in 1936 and interned at Sinai Hospital, Baltimore, Maryland. Dr. Zeman did special postgraduate work in oto-laryngology at the University of Pennsylvania School of Medicine. He is a Fellow in the American College of Surgeons.

Pertinent Paragraphs

A new 13-program radio transcription series entitled, "Superstition or Science," prepared by the AMA's Bureau of Health Education, is available for broadcasting over local radio stations under the auspices of state and county medical societies. The series is designed to show how "old wives' tales" can sometimes lead us far astray and other times to actual cures for disease.

An effective and inexpensive method of treating pernicious anemia has been discovered by the administration of vitamin B-12 through inhalation or use of a nasal spray, according to an article in the Archives of Internal Medicine of the AMA written by Raymond W. Monto, M.D., and John W. Rebuck, M.D., Detroit, Michigan. They report this method of therapy has been highly effective and produced no evidence of toxicity or sensitivity.

Edwin L. Crosby, M.D., Baltimore, director of the Joint Commission on Accreditation of Hospitals, was recently appointed to the post of executive director of the American Hospital Association, Chicago. He will assume the position vacated by George Bugbee, who is the new president of the Health Information Foundation in New York.

According to Walter B. Martin, M.D., Norfolk, Virginia, president-elect of the AMA, while the cost of living has increased almost 91 per cent from the 1935-1939 period and average weekly wages have increaced 165 per cent, medical costs are up only 65½ per cent and physicians' fees rose only 48 per cent.

The Third International Poliomyelitis Conference will be held at the Orthopedic Clinic, University of Rome, Rome, Italy, from September 6-10, 1954. Registration days will be September 4, 5 and 6. A program of the conference is available on request at the KSMA headquarters office.

County Society Reports

GRANT

The Grant County Medical Society met March 3, 1954, with the Mobile Cancer Clinic Group at the Carlsbad Hotel. Guest speaker was Herbert T. Ransdell, M.D., assistant professor of surgery at the University of Louisville School of Medicine.

A film, "The Warning Shadow," was shown and followed by a short discussion of carcinoma of the lung. Prevalence, etiology, symptomatology, diagnosis, treatment and follow up were discussed.

Announcements were made of the Special Meeting of the KSMA House of Delegates in Lexington, April 15, the County Society Officers Conference April 15, also in Lexington, and the Kentucky Obstetrical and Gynecologic Society Meeting, April 2-3, at Frankfort.

Members present included Doctors: O. A. Cull, Lenore P. Chipman, Claude C. Waldrop and Virginia D. Kratz. Other guests in addition to Dr. Ransdell were Miss Mae Riley, R.N.; Mrs. Ernest B. Vogt, secretary; Miss Joyce Caribaldi, volunteer, and Mr. Herman Meredith, X-Ray technician. All of the guests are members of the Cancer Clinic.

Virginia D. Kratz, M.D., Secretary

HOPKINS

The monthly dinner meeting of the Hopkins County Medical Society was held at the Hopkins County Hospital, February 25, 1954, with M. M. Mahr, M.D., presiding.

It was noted that flowers had been sent to the widow of C. B. Johnson, M.D., Earlington, who died February 21, 1954. A recommendation was made that a letter of sympathy from the society also be sent to Mrs. Johnson.

The following physicians were present at the meeting: F. F. Ferguson, J. A. Freeman, M. E. Arnold, N. Calhoun, L. C. Trover, F. S. Trover, F. P. Strother, F. A. Scott, R. E. Mardis, M. M. Mahr, J. L. Salmon, A. F. Finley, P. J. Malagrino, R. J. Dancey, M. W. Hammack, J. E. Corum, D. W. Anderson, W. F. Stucky, and W. W. Wainer.

M. E. Arnold, M.D., Secretary

LETCHER

The Letcher County Medical and Dental Society was called to order March 31, at the County Health Office, Whitesburg, by B. C. Bach, M.D., president. A discussion was held in regard to medical service for indigent patients.

It was moved to change the monthly meetings to bi-monthly meetings. The motion carried. In the future regular meetings will be held on the last Tuesday of each month.

Members present were Dr. Bach, T. M. Perry, M.D., R. Dow Collins, M.D., Lee Moore, D.D.S., Carl Pigman, M.D., and Owen Pigman, M.D.

Owen Pigman, M.D., Secretary

McCRACKEN

The monthly dinner meeting of the McCracken County Medical Society was held March 24, 1954, with W. K. Sloan, M.D., presiding. He introduced Dr. Frank Williams, president of the local dental association, who refuted the recent local antagonism toward flourination of city water by the Jackson Purchase Chiropractors Association. It was urged that individuals lend support to the proposed program.

T. E. Ruff, M.D, local urologist, discussed "Prostatism" on the scientific program.

A motion was made by E. Sloan, M.D., that the society instruct its delegates to vote in favor of admitting colored physicians to the society. Eugene Blake, M.D., amended the motion to indicate that some type of suggestion be made so that the colored physicians would not participate in social functions. The amended motion passed.

Burton Haley, M.D., moved that delegates be instructed to vote "no" with reference to the new medical school in Lexington.

Robert T. Brooks, M.D., was accepted into membership by the McCracken County Medical Society. A letter to Vernon Pace, M. D., from Lawrence T. Minish, Jr., M.D., was read. It requested a list of qualified specialists for the purpose of medical education. The society decided to submit the names of all men limiting their practice to one particular field who would participate in the program.

O. D. Maxey, M.D., moved that the society hold a cocktail hour before the district councilor meeting in April. The motion carried. Dr. Eugene Blake moved that the society supply a cocktail party for the Southwestern Medical Meeting. The motion carried.

Following the Library Committee Report, E. W. Jackson, M.D., moved that the society buy books instead of journals for the library. The motion carried.

M. W. Fowler, Jr., M.D., Secretary

PIKE

The Pike County Medical Society held its regular meeting February 16, in Pikeville with Charles C. Rutledge, M.D., presiding. Nineteen members and four guests were present.

John Archer, M.D., Prestonsburg, district councilor, urged everyone to read a new feature of the Journal of the KSMA, "The Washington News Digest" in order to gain more knowledge about current medical legislation.

Discussion was held in regard to the necessity for a grievance committee in Pike County, with the majority of members present supporting such action. It was moved that a publicized grievance committee be appointed through which the public and physicians could discuss their grievances. Details of the committee will be worked out and presented at the next meeting.

Guest speaker on the scientific program was Ralph Angelucci, M.D., Lexington neurologist, who presented a discussion on the treatment of head injuries including the different types which might be encountered, giving their differential diagnosis and the recommended treatment. In particular, he emphasized the emergency treatment in addition to subsequent treatment necessary for complete recovery.

Dr. Archer invited the Pike County Medical Society to attend the Fourteenth Council District Meeting in Prestonsburg, April 7, 1954.

Guests of the society in addition to Dr. Angelucci and Dr. Archer were: Ballard W. Cassady, M.D., and Frank Wight, M.D., both of Lexington.

Russell H. Davis, M.D., Secretary-Treasurer

PIKE

The Pike County Medical Association held its regular monthly meeting Tuesday, March 16, 1954, at Katherine's Koffee Shop. Nineteen members and one guest were present. Asa Barnes, M.D., director of the UMWA Welfare and Retirement Fund, was the association's guest.

T. I. Doty, M.D., chairman of the Charity Committee, reported that his committee is contacting all of the local squires and arrangements will be made with these men so that any patients lacking medical care because of financial reasons will receive it. It is anticipated that those seeking medical care as county patients who are undeserving will be eliminated.

A discussion was held on the new United Mine Workers Memorial Hospital Association and the effect it will have on the practice of medicine in eastern Kentucky. Dr. Barnes stressed the point that according to U. S. Public Health surveys, four and one half beds per thousand population are needed to take care of hospital patients. He also noted that with the new beds available from the Memorial Hospital Association, there still will be only approximately three beds per thousand population in eastern Kentucky.

A new member was taken into the Pike County Medical Association, William C. Roland, M.D., a member of the American Board of Orthopedics who is now in practice in Pikeville.

Charles C. Rutledge, M.D., presided over the meeting. A scientific paper which had been prepared by William C. Hambly, M.D., will be given at a later date, due to the amount of business discussion on hand.

Russell H. Davis, M.D., Secretary

SCOTT

The Scott County Medical Society met Thursday, March 4, 1954, at the John Graves Ford Memorial Hospital in Georgetown, with 9 members present.

The secretary read a letter from Mr. Joe Sanford, executive secretary of the Kentucky State Medical Association, in regard to raising the annual dues from $25.00 to $35.00 per year.

The secretary also reported that the 1954 membership cards had been delivered to Doctors: W. S. Allphin, A. F. Smith, H. G. Wells and C. R. Lewis, as well as to the four emeritus members.

The following physicians were present at the meeting: C. R. Lewis, L. F. Heath, P. H. Crutchfield, W. S. Allphin, E. C. Barlow, H. G. Wells, F. W. Wilt, A. F. Smith and H. V. Johnson.

H. V. Johnson, M.D., Secretary

SHELBY-OLDHAM

"Allergy in Pediatrics" was discussed by Kenneth Crawford, M.D., Louisville, at a dinner meeting of Shelby-Oldham County Medical Society at the Old Stone Inn, March 25. B. F. Shields, M.D., president, presided.

The Secretary announced that the County Society Officers' Conference would be held in Lexington, April 15. A number of members indicated that they would attend.

The following members were present: H. H. Richeson, M.D., George Ray, M.D., M. H. Skaggs, M.D., George Perrine, M.D., H. B. Mack, M.D., H. T. Alexander, M.D., J. T. Walsh, M. D., S. B. May, M.D., B. B. Sleadd, M.D.

B. F Shields, M.D., Charles Chatham, D.D.S., A. L. Heise, D.D.S., M. D. Klein, M.D., L. B. Sternberg, M.D., A. C Weakley, M.D., A. D. Doak, M.D., Don Chatham, M.D., and C. C. Risk, D.D.S.

C. C. Risk, D.D.S., Secretary.

SCOTT

F. W. Wilt, M.D., discussed the subject of measles, stressing the etiology, symptoms, complications and treatment, at the April 1 meeting of the Scott County Medical Society, held at the John Graves Memorial Hospital in Georgetown. Mrs. Teegarden, superintendent of the hospital, was a guest of the society.

Dr. Wilt reported that 118 cases of measles had been reported in March and indicated that there were probably many more that had not been reported.

The following physicians were present: L. F. Heath, P. H. Crutchfield, W. S. Allphin, H. G. Wells, A. F. Smith, C. R. Lewis, F. W. Wilt, E. C. Barlow, and H. V. Johnson.

H. V. Johnson, M.D., Secretary

The 22nd annual National Convention of the American Society of Medical Technologists will be held at Miami Beach, Florida, June 13-17, 1954. The co-headquarters hotels are the Delano and the DiLido, according to Mrs. Maxine T. Ace and Mrs. Anna L. Rundell, Miami, co-chairmen of the publicity committee.

In Memoriam

LOUIS H. MULLIGAN, M. D.

Lexington

1869 - 1954

The Fayette County Medical Society lost one of its oldest and best known members when Dr. Louis H. Mulligan died on February 13, 1954.

Dr. Mulligan was born in Lexington in 1869. He was graduated in medicine at the Louisville Medical College in the class of 1896. He practiced psychiatry for a few years and then went abroad to study dermatology under the old masters in Vienna. In 1913 he entered the private practice of his specialty in Lexington and continued until 1952 when he retired.

He was probably the first well trained dermatologist in Kentucky. He was a long-time member of the Fayette County Medical Society and a fellow of the American Academy of Dermatology and Syphilology.

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7. Diagnosis and Management of Head Injuries

Medical sessions—10:00 a. m. to 12 noon
2:00 p. m. to 4:45 p. m.

Seven hours of A.A.G.P. attendance credit will be allowed for this meeting. Luncheon will be served during the noon recess, and there will be no registration fee for this meeting.

IN MEMORIAM

(Continued from page 374)

Dr. Mulligan had a very likeable and colorful personality. He was a modest, kindly, witty man. He was well informed in his special field, and a skillful practitioner. He also had rich experiences in psychiatry, but seldom used the psychiatric approach in managing his patients.

His contributions to medical literature were few, and yet those few were so good that his contemporaries still recall after thirty years, his memorable essay on scabies. Dr. Mulligan had many close friends, probably the closest was the late Thomas Kinnaird, M.D., Their friendship was almost a legend.

Dr. Mulligan had one consuming hobby, photography. It is hard to say which he liked the better, dermatology or photography. He was a founding member of the Lexington Camera Club, attended their meetings regularly, and took an active part in their discussions. His photographs have won several prizes for artistic excellance. He was still working in his dark room a few weeks before he died.

Dr. Mulligan was married in 1918 to Sadie Daily, who has been a faithful companion. He is also survived by two daughters; Grace, Mary (Mrs. Robert E. Petsch) and two grandsons.

He was grand old man with many unique and lovable qualities and he will long be remembered by his friends whose deep sympathy is extended to his surviving family.

Charles N. Kavanaugh, M.D.
William D. Reddish, M.D.
Carey C. Barrett, M.D.

RUSSELL E. KINSEY, M.D.

Dry Ridge

1905 - 1954

Dr. Russell E. Kinsey died in his sleep March 12, 1954, at his home, Restlands, near Dry Ridge, in Grant County. His death was attributed to coronary thrombosis.

He was graduated from the University of Cincinnati College of Medicine in 1932 and began his early practice in the mountains of Leslie County. He opened an office in Williamstown in 1934 and continued practicing there for 20 years.

During the Korean conflict he served with the medical corps of the United States Navy and attained the rank of lieutenant com-

mander. After a year's service he received an honorable discharge and resumed his practice in Williamstown.

Dr. Kinsey was a member of the Grant County Medical Society of which he served two terms as president, the Licking Valley Medical Society, and the Kentucky State Medical Association.

CURTIS B. JOHNSON, M.D.

Earlington

1879 - 1954

Dr. Curtis B. Johnson, 74, of Earlington, died February 21, 1954, at Jennie Stuart Hospital in Hopkinsville after an illness of several days.

A 1900 graduate of the Medical Department of the University of Louisville, Dr. Johnson began practicing in Earlington where he continued for half a century, retiring last year.

Throughout his life, Dr. Johnson was active in both medical and civic organizations. The Earlington Civic Club had selected him as the outstanding citizen of 1953 for his service as former mayor, city councilman, member of the City Board of Education and other activities.

Dr. Johnson was a member of the Hopkins County Medical Society and the Kentucky State Medical Association.

KARL N. VICTOR, M.D.

Louisville

1900 - 1954

Dr. Karl N. Victor, Louisville, died March 9, 1954, of a back injury he suffered in a fall in his office building a few weeks previous to his death.

A graduate of the University of Louisville School of Medicine in 1924, Dr. Victor specialized in ear, nose and throat. He practiced in Louisville for 30 years.

Dr. Victor was a member of the staff of the Jewish Hospital and Norton Infirmary, in Louisville. He held membership in the American Academy of Otolaryngology, the Jefferson County Medical Society, the Kentucky State Medical Association, and the American Medical Association.

Pension and retirement plans, accident and sickness protection have grown spectacularly over recent years, it has been reported by the Insurance Economics Society of America. More than seven billion dollars was voluntarily paid into such plans in 1952 by American citizens. This is more than triple the comparable figure a decade ago.



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BOOK REVIEWS

CARE OF THE LONG-TERM PATIENT—SOURCE BOOK ON SIZE AND CHARACTERISTICS OF THE PROBLEM. Prepared for the Conference on Care of the Long-Term Patient. Public Health Service Publication No. 344, on sale by the Superintendent of Documents, Government Printing Office, Washington 25, D. C.

This publication is not the sort one can read for review. It is a large collection of statistical material from many sources both published and previously unpublished. There are 69 tables grouped under these headings: persons with long-term disabling illness, the patient at home, the patient in an institution, and integration of facilities and services. This vast and awesome compilation should be of help to those planning the care of such patients in a community.

Reviewed by Jack Chumley, M.D., Louisville.

NARCOTICS AND NARCOTIC ADDICTION, by David W. Maurer, Ph.D., and Victor H. Vogel, M.I.D., published by Charles C. Thomas, Springfield, Illinois, 1954, $7.50.

Quite aside from the fact that this book has a good bit of local interest in that it was written by a professor of the University of Louisville and a medical officer formerly at the U.S. Public Health Service Hospital in Lexington, it has a number of virtues for which it can be recommended to a wide variety of readers.

Considered as an addition to medical knowledge and as an aid to medical education, "Narcotics and Narcotic Addiction" is obviously valuable, as it concentrates within reasonable limits about all that any physician in private practice need know about the subject. Even though no special niche for this book may be found in the crowded curriculum of medical schools, every student resident and practicing physician should read it, not only for a deeper, humanitarian insight into the problem but also for the downright pleasure to be obtained from a well written book. The jacket states that the book was written for government officials and law enforcement officers, including police, narcotic agents, judges, attorneys, social workers, clergy, and others. This is all very well, but certainly the medical profession should have been included in the list because our education along these lines has been pretty hit or miss and not integrated as here.

Of late there has been a great deal of lurid, sensational publicity in the popular press con-

cerning narcotic addiction. Anyone, whether or not he is a member of any of the above mentioned groups, who has been disturbed by such accounts, may turn to this book and find truthful answers to his questions. These answers may not be comforting but they are authoritative for the authors are acknowledged experts in their field. So here again the number of potential readers should be increased because the book is seldom too technical to be easily understood by those without specialized vocabularies.

Anyone who is interested in words will be fascinated by the "glossary of terms commonly used by underworld addicts." It must be an evidence of the adolescent-like growth and mercurial fluidity of our American language that so many of these terms are in everyday use with absolutely no connotation of addiction or criminality. In closing, one might ask our readers if there is a croaker among them who can be certain he hasn't been scored on for some Miss Emma by means of a twister thrown by a Do popper with burned out lines and so close to the whips and jingles he had to go to the skin?

Reviewed by Jack Chumley, M.D
Louisville

Dr. Allman States AMA Position On Medical Care

(The following material consists of excerpts from a statement of the American Medical Association made by David B. Allman, M.D., Atlantic City, New Jersey, member of the Board of Trustees and Chairman of the Committee on Legislation of the American Medical Association, regarding H. R. 8356, in addressing the Committee on Interstate and Foreign Commerce of the House of Representatives, April 5, 1954)

The AMA is in complete accord with the principal purpose of the bill, which is to promote the best possible care on reasonable terms. Our Association has for many years adhered to a policy which parallels the above referred to purpose of this bill. We are also in agreement that the most feasible method for most of the people is through voluntary health insurance. The Association, however, seriously doubts whether H. R. 8356 is essential and whether it will, in fact, accomplish the desired results.

In determining its essentiality we believe that it is necessary to give full and complete consideration to the tremendous strides which voluntary health insurance has made and the simultaneous improvement in benefits provid-

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ed to meet the desire of the public for more adequate protection.

Inasmuch as complete statistical data outlining this expansion and growth have been made available by previous witnesses, I shall not repeat these figures at this time. I understand you have also been briefed on the progress and prospects of the newest area of health insurance—"major medical expense" coverage.

It is our belief that the figures which have been presented hold real promise for still greater progress. This fact plus the demonstrated ability of the industry to meet the needs and demands of the public indicates to us that it is unnecessary for the federal government to enter the field.

There is a limit to the number of insurable people in this country, and a limit to what can be accomplished by insurance. In any effort to solve the economic problems of medical care, it is essential to consider two groups of individuals: (1) those who are able to pay the normal costs of medical care, and (2) those who are indigent. Most of the American people fall within the first group and have access to the many forms of health insurance now offered. Some of these have elected to carry their risk either because of their financial ability to do so or because they are not convinced of the wisdom or necessity of purchasing protection against medical expenses in advance. As the desirability of insuring against medical expenses is more generally accepted and as the improvement and development of new types of coverage evolve, it is reasonable to expect that the maximum number of "insurables" will be covered.

The other group, the indigent, poses distinctly different problems. These individuals do not have the funds with which to purchase insurance and are dependent, in some measure, on outside assistance for the basic necessities of life. The American Medical Association believes that if the medical care problems of this group cannot be solved by the individuals or their families, the responsibility should be assumed by the local and state government.

As an Association we have been greatly concerned with the individuals in this category and are making efforts to aid in the solution of this very difficult problem. Through our Council on Medical Service we have undertaken a series of studies of the organization and operation of state and local indigent medical care plans which are effective in meeting the need. Fifteen such studies have been made to date and five more will be completed this summer.

Recognizing that the medical profession is only one of a number of parties concerned in the total health care picture of the indigent a

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permanent study group comprised of representatives of the American Medical Association, the American Hospital Association, the American Dental Association, the American Public Health Association and the American Public Welfare Association has been established.

The Association is considering the establishment of a field service to assist state and county medical societies in developing programs in this field. As a pilot project along this line, the field staff spent five weeks in one state during the summer of 1953 to help collect basic data and information which might lead to a formal state organization and to adequate financing for an indigent medical care program.

We hope that expanded efforts by private agencies and an awakening by state and local governments to their responsibilities to the indigent will lead to a solution to the problem. It is not clear, however, how persons in the indigent group will be assisted by the provisions of the bill under consideration, without some form of federal subsidization paid through the insurance companies. We believe this would be objectionable.

Expressions of opinions from the insurance industry plus our analysis of the bill have led us to the conclusion that a federal reinsurance system such as proposed by the bill could not be expected to achieve the objective set forth in this legislation. In addition, the measure as drawn would place extensive regulatory power in the Secretary of the Department of Health, Education, and Welfare. The concentration and delegation of such potential power and control over a vital branch of American industry in a department of the Executive Branch of the government without clear and convincing evidence of need is extremely difficult to justify.

Let me reiterate that we believe the sponsors of this proposal are deserving of commendation in attempting to spread voluntary health insurance through private initiative. Nevertheless it is the belief of the American Medical Association that the bill will not fulfill its intended purpose and may, in fact, inhibit the satisfactory progress which is now being made by voluntary insurance companies. For these reasons it is the recommendation of the Association that this bill should not be reported favorable by this Committee.

WASHINGTON NEWS DIGEST

(Continued from page 370)

Doctor Draft Amendment

This bill, an outgrowth of the Peress case, swept through the Senate without objection. It may be law by the time this is published. It would amend the Doctor Draft act to permit the services to keep on duty as an enlisted man, assigned to professional tasks, anyone called under the Doctor Draft act whose loyalty is questioned. Defense Department has promised to investigate such cases immediately, so that the man can be cleared promptly and offered a commission or discharged. The discharge would state that action was taken on loyalty grounds.

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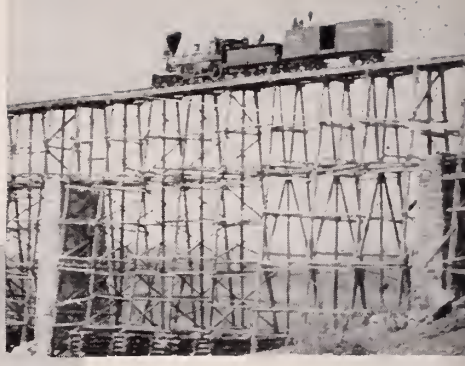
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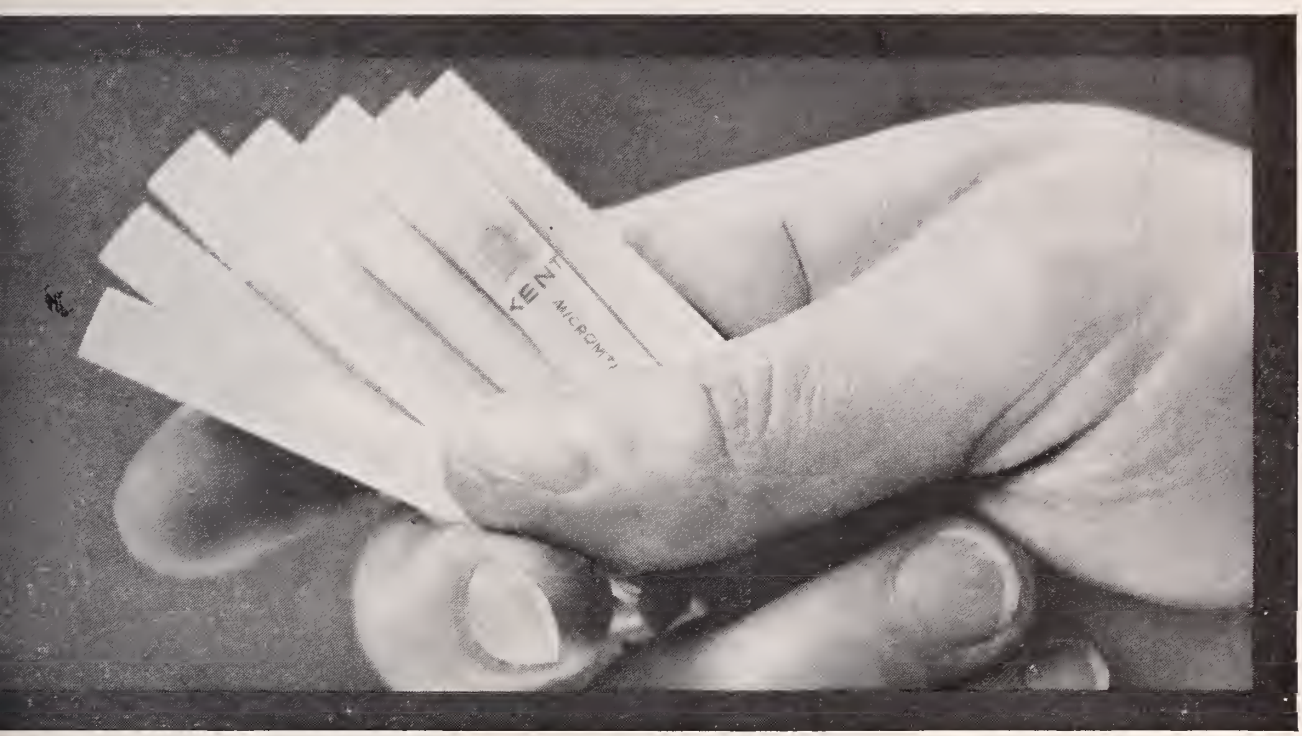
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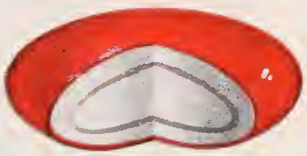
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2. Gray, C. H., and Millar, H. R.: Brit. M. J. *4824*:1361 (June 20) 1953.

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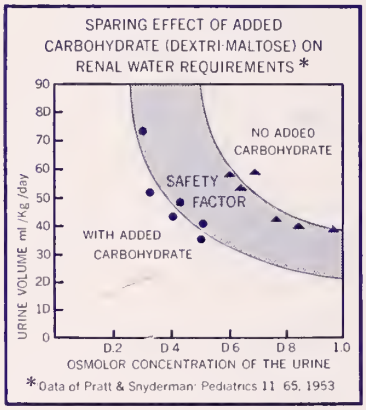
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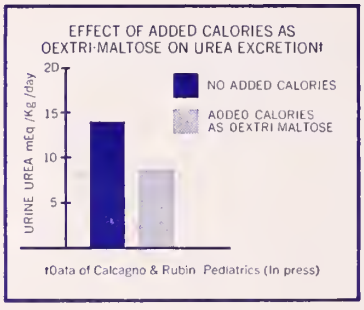
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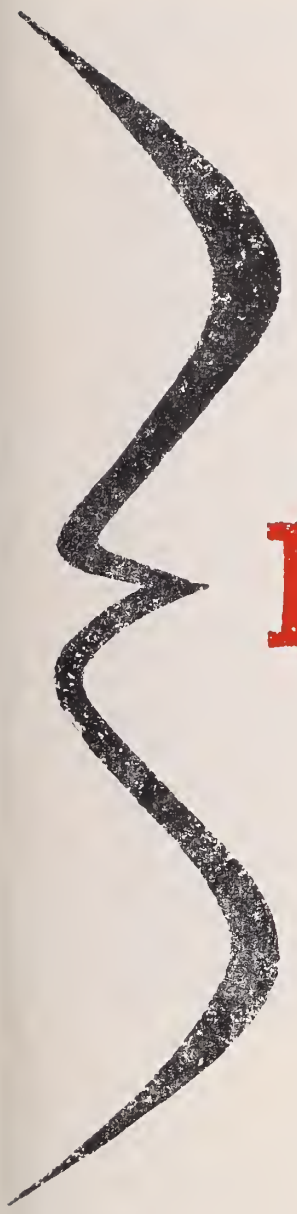
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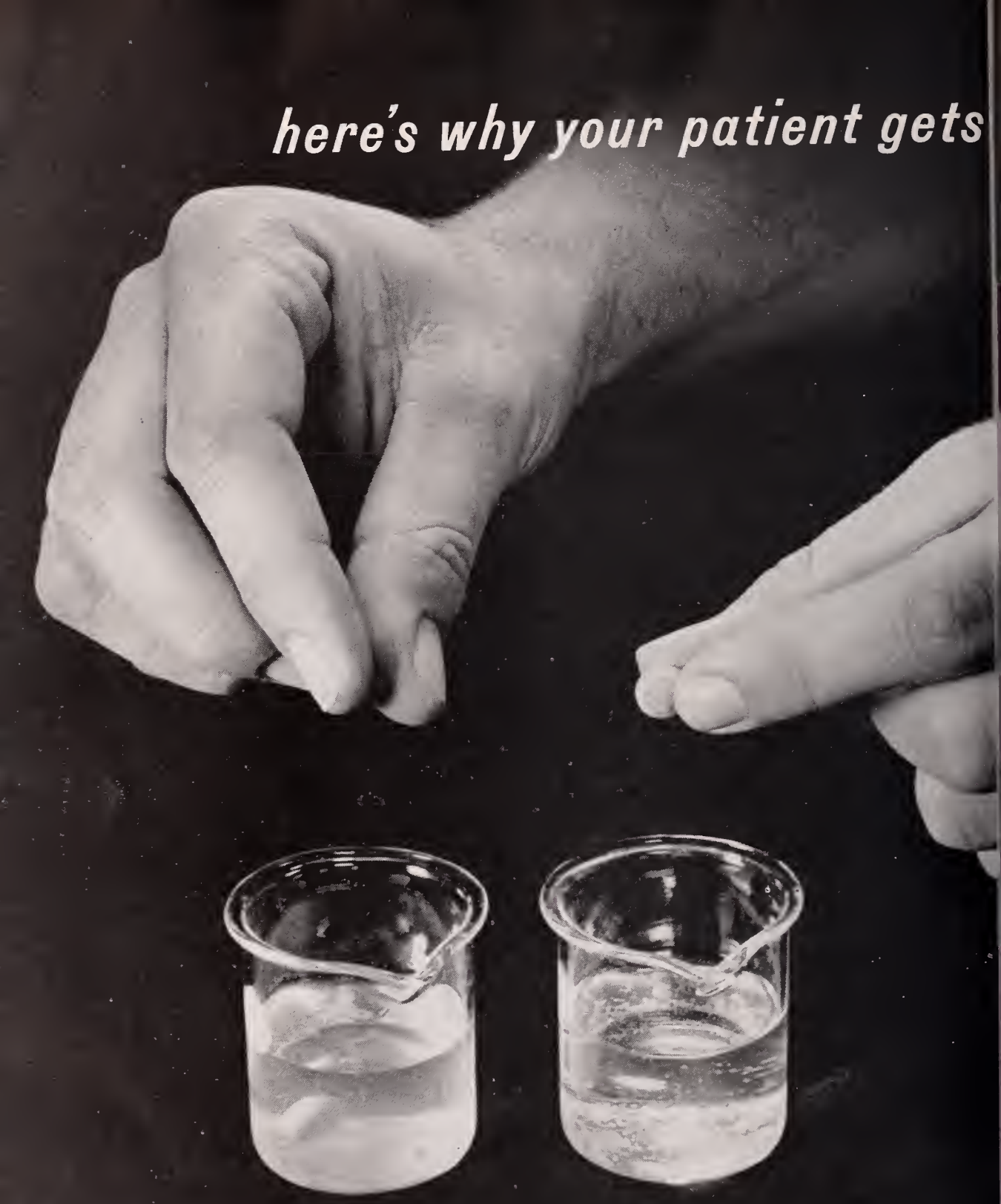
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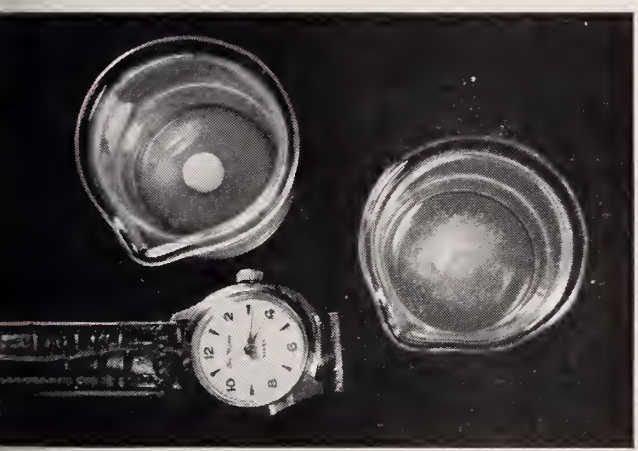
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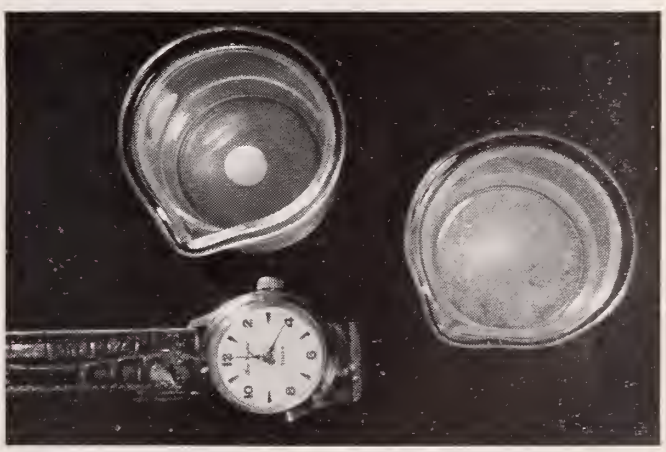
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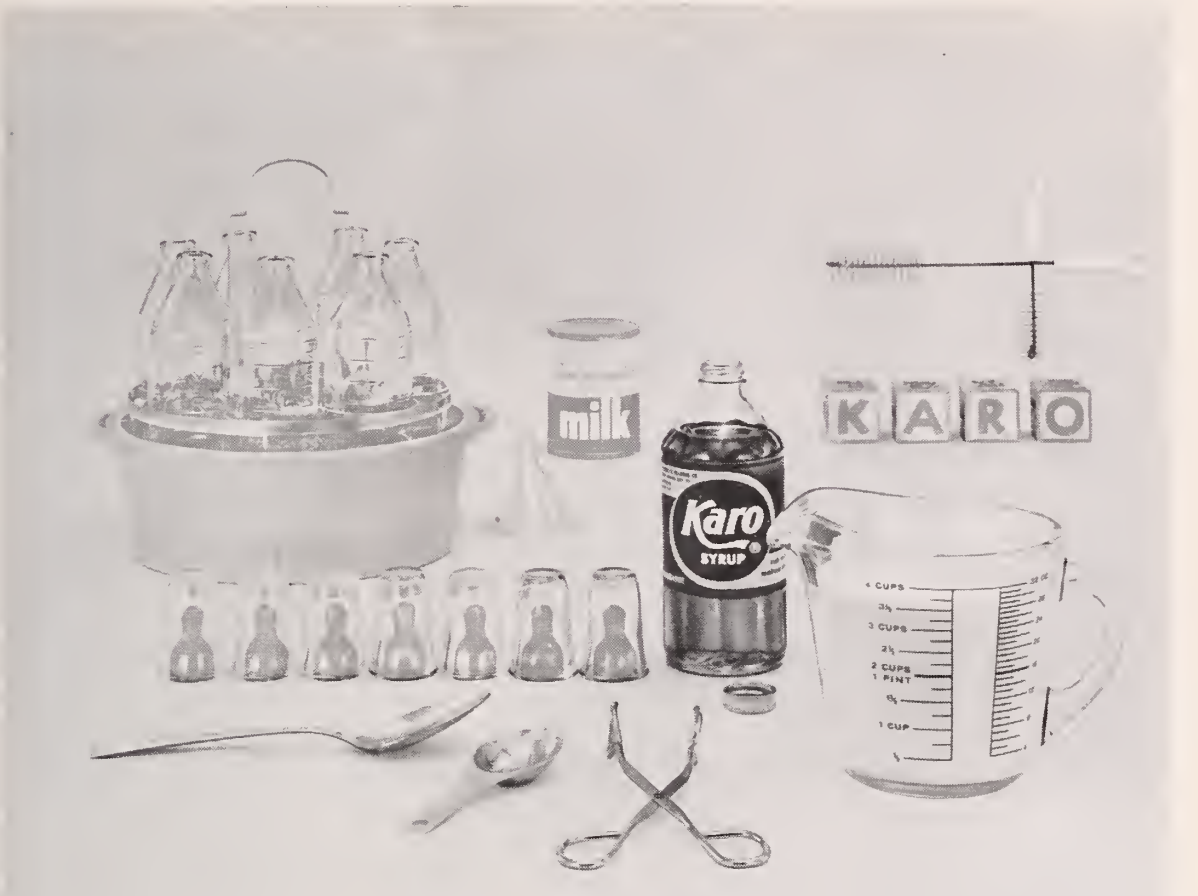
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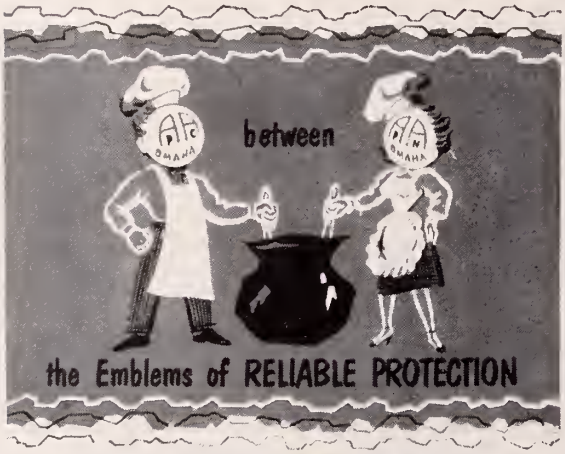
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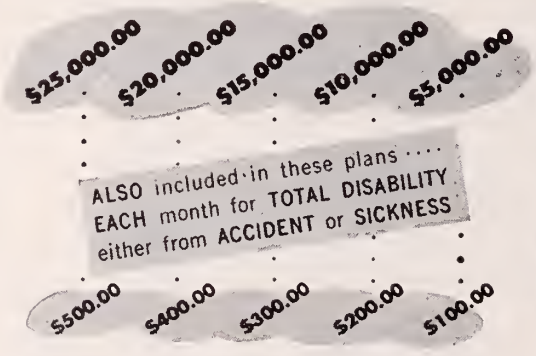
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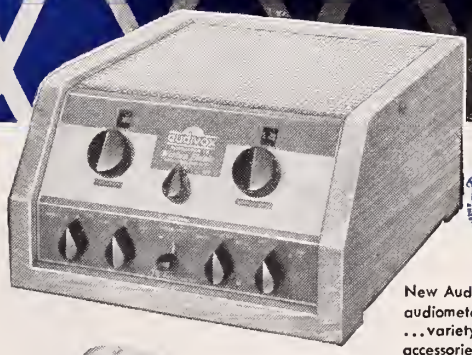
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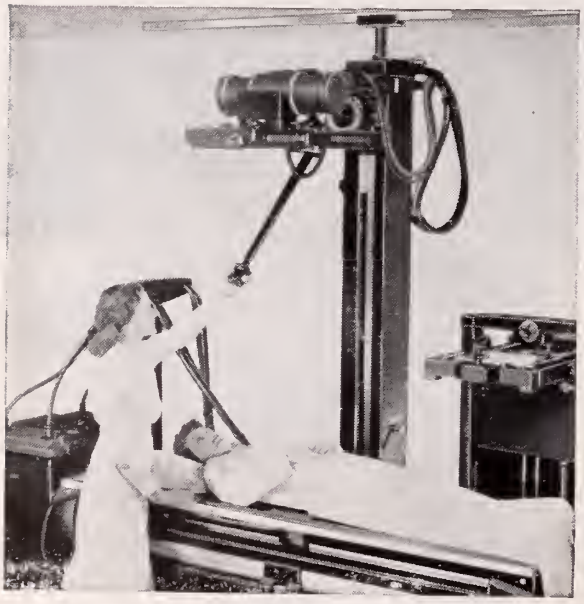
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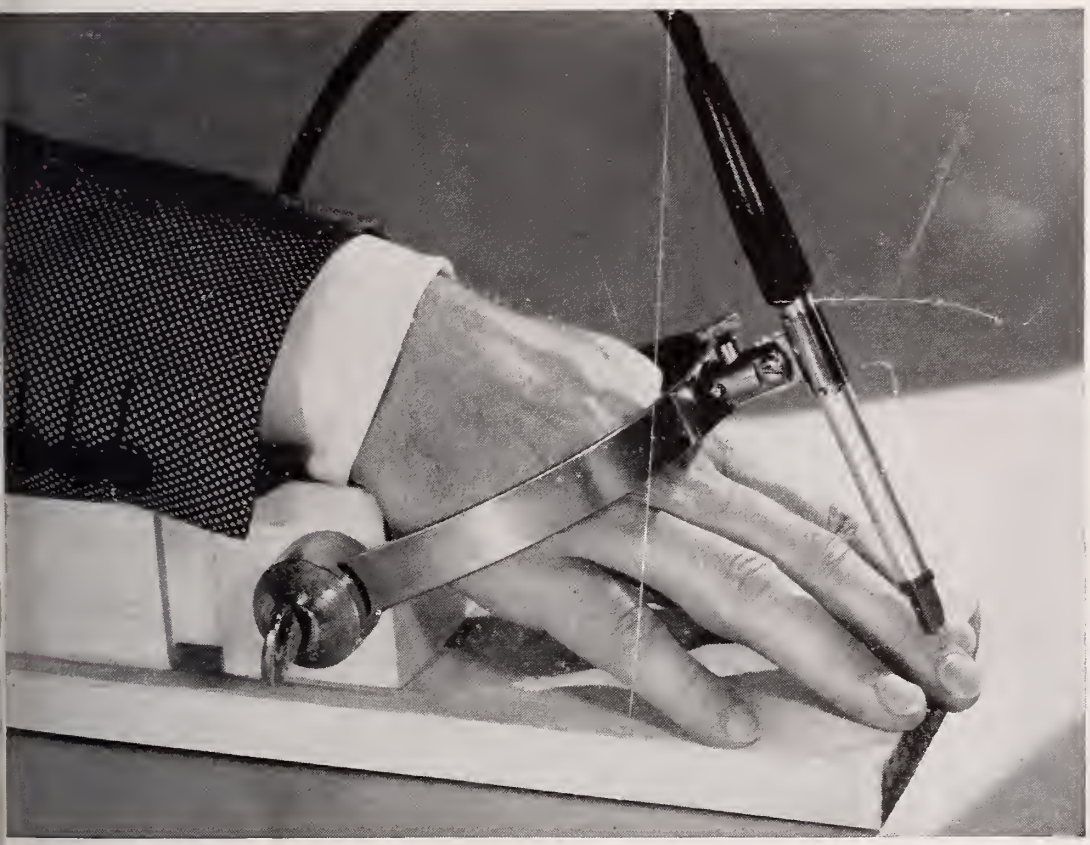


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1. Malleson, J.: Lancet 2:158 (July 25) 1953. 2. Goldzieher, M. A., and Goldzieher, J. W.: Endocrine Treatment in General Practice, New York, Springer Publishing Company, Inc. 1953, p. 23.

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The JOURNAL of the
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What Can We Do About Polio—1954?*

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Georgia Warm Springs Foundation
Warm Springs, Georgia

During the past five years several momentous events have taken place on the frontiers of research in poliomyelitis. The pace is quickening with a widespread anticipation of a foreseeable end to the problem of prevention of paralysis if not of the infection itself. For lay (and professional) readers excellent articles appeared in the February 22 issue of Life magazine and in the March 29 issue of Time. It is therefore appropriate to outline and summarize our present status in the realms of prevention of paralysis and treatment of the after effects.

Prevention of Paralysis

CURRENT CONCEPTS OF PATHOGENESIS AND IMMUNOLOGY[1]: Most workers now agree that poliomyelitis is spread principally by intimate personal contact. Many asymptomatic carriers exist, in addition to those with non-specific symptoms, who carry the virus either in the pharyngeal secretions or in the bowel contents whence spread to another can occur by fecal or respiratory contamination. Once within the recipient's pharyngeal-enteric tract, infection with invasion of the soma may or may not take place. When the mucous membrane barrier is invaded by the virus either a viremia or direct spread and propagation of the virus along nerve pathways has been demonstrated in both animals and man. Local trauma to the barrier, such as tonsillectomy, appears to facilitate direct nerve pathway spread to the central nervous system. Evidence for this is available experimentally and in man by the high incidence of bulbar polio when the infection occurs shortly after tonsillectomy. In most human instances, however, it appears that a viremia is frequent but only for a short while several days after exposure and presumably preceding the onset of any characteristic symptoms. The problem of prophylaxis against polio apparently involves essentially the same systemic and local immune mechanisms as in other infectious diseases.

Repeatedly it has been demonstrated that the great majority of adults, especially in an urban population, have circulating antibodies against polio virus although very few were ever known to have clinical polio. Why then has there been an increase in the past few years in the number of adults so that about twenty per cent of the diagnosed cases are over fifteen years of age? Why, also, are more second attacks being reported? The principal answer was forthcoming from the Foundation-supported research on the various species of virus capable of producing paralysis in man. After nearly three years and the careful study of one hundred strains, it was found that there are three distinct immunologic types which have been named Types I, II and III. Experimentally animals can be immune to reinfection with one strain when a sufficient titre of circulating antibody to that type is present. Yet at times when challenged by an unusual route or with an overwhelming dose, reinfection can occur. More commonly, however, infection with a different type of virus usually results in a clinical attack despite circulating antibodies to another type. Clearly then any preventative must be effective against each of the three specific types. Further studies on samples of human sera from many parts

*Read before a meeting of the Second Councilor District of the Kentucky State Medical Association, Owensboro, March 23, 1954.

of the world are now in progress to determine the prevalance of antibodies to the three types. Adult and second attacks probably result from infection with a different strain of virus from that against which they had circulating antibodies.

What then are the probabilities of a given individual acquiring paralytic poliomyelitis? It has been estimated (and statistical analysis is obviously impossible at this time) that a child ordinarily without any specific prophylaxis would have at least a two hundred to one chance of not having the paralytic form of the disease. Yet, during the past five years continued large outbreaks have occurred in many parts of the country, and each of us is concerned not with epidemic numbers but with individuals in our own family and their chances of being afflicted.

PASSIVE IMMUNITY—GAMMA GLOBULIN: As the result of encouraging findings with monkeys experimentally protected against inoculation with all three types, in 1951-52 field trials in human poliomyelitis were conducted in three epidemic areas. The results indicated that "cases occurring during the first week following injection of gamma globulin were significantly modified in severity. During the next period of four weeks a high but not complete degree of protection was demonstrated."[2] Paralytic cases developing during this period were eighty per cent fewer than among controls receiving gelatin.[3] In 1953 mass prophylaxis with gamma globulin was used in twenty-three counties in different parts of the country. In only one was there a subsequent rapid decline in case rate. A committee of experts studying the results declared that there was not enough information to permit drawing any conclusions whether or not gamma globulin had an effect in preventing or alleviating the disease when used as it was in 1953.[4] In most instances the inoculations were given after or shortly before the peaks of the respective epidemics were reached. It will be remembered that significant protection against paralysis was not observed under test conditions until one week after injections. This fact also substantiates the expected findings among family contacts when gamma globulin was given as soon as the illness was recognized in one member of a household. The greater amount of G.G. was used in this way and the committee concluded that there was no measurable reduction in the number of subsequent paralytic cases in these households or measurable effect on the severity of the ensuing paralysis.

On March 7, 1954[5] the National Foundation for Infantile Paralysis announced the plans for the use of G.G. this year. There will be 1,900,000 doses of G.G. made available for group inoculations. This amount will be supplied by the National Foundation and the American Red Cross and distributed by the Office of Defense Mobilization. This total of G.G. will be released by August 31, 1954. Of the total, 850,000 doses will be made available immediately to State Public Health officers. Another 850,000 will be made available on request as needed during the epidemic period and 200,000 doses will be held in reserve to cover emergencies. The method of using G.G. will be entirely at the discretion of the State Public Health Officer but a slightly higher dose than used in 1953 is recommended.

It will be remembered that at best the protection afforded by G.G. is short lived (from the second through the fifth week after inoculation) and represents passive immunity only. What can be expected this year from more effective prophylactic measures involving vaccination?

ACTIVE IMMUNITY—VACCINATION[6]: A very important contribution to the field of immunization came from the G.G. field studies. It was found that in humans a very low concentration of type specific antibodies can protect man. To provide active immunity of reasonable duration a polyvalent vaccine is required. This, unlike G.G., would also involve the body's defense mechanisms which conceivably includes the development of local tissue immunity as well as circulating antibodies. Rapidly other events took place whereby large quantities of virus could be grown on monkey kidney tissue in a nutrient broth. Thus a large safe source of virus, free from the danger of allergic encephalomyelitis, became available for the production of a vaccine for humans. All three types can be grown in this manner and by a series of painstaking steps the viruses are killed with formaldehyde and the vaccine is carefully prepared. In three separate laboratories each batch is tested for sterility and viral pathogenicity both in living monkeys and in tissue culture.

By April 1954 over 6000 humans have received inoculations of the formalin-killed vaccine. This is to confirm the safety of previously-given injections in small samples of individuals in 1952 and

1953. From these selected trials Dr. Salk has found that significant numbers retained measurable antibody titres for as long as seven months after original inoculation. Also that the "recall" reaction to a booster dose produced a marked rise in circulating antibody twelve days after reinoculation. Such a response has been observed for all three known types of virus.

Beginning this spring in the South and advancing northward areas have been selected in which a mass field trial of the vaccine will be conducted. Around half a million children between six and nine years of age will be inoculated. In some regions only those in the second grade will receive injections while the children in the first and third grades serve as controls. In larger areas one-half of all children in the first three grades in school will be vaccinated. The other half will receive a control solution of an ineffective fluid. There will be three injections of one cubic centimeter each given in the arm. The second will be given one week after the first and the third at least four weeks after the second. In these areas, of course, gamma globulin cannot be used except for control of hepatitis and measles so that the validity of the vaccine trial will not be jeopardized. The results will not be available until some time in 1955.

In light of the recently published report about the insufficient data on the effects of G.G., it is imperative that the medical profession cooperate wholeheartedly with the conditions of the vaccine field trial. Yet human nature being what it is, when threatened, the individual demands every available protection. Remembering the low morbidity of paralytic polio, it is essential to repeat these previously demonstrated preventive measures.

GENERAL MEASURES[7]: (1) Avoid intimate contact with strangers by susceptibles, especially children.

(2) Defer tonsillectomy and adenoidectomy until after an epidemic.

(3) If they can be postponed with safety, diphtheria, tetanus and pertussis immunizations in children over one year of age should not be carried out during polio epidemics.

(4) Prevent chilling and fatigue, particularly when any child is sick during the polio season.

(5) If at all suspicious of the diagnosis, put any patient at complete bed rest until certain.

(6) Reassurance: Of one hundred diagnosed cases of polio, about six may die; twenty have significant paralysis but around forty to fifty will develop active immunity with no residual untoward effect.

Treatment of Paralysis

SAVE LIFE: Aside from the overwhelming onslaught of a very virulent infection, death in polio results from involvement of the cranial nerves and/or respiratory apparatus. It is therefore mandatory to differentiate the several types of involvement and to institute the appropriate treatment.[8] In general, the most common serious form of respiratory paralysis is the spinal, producing weakness of the intercostals and/or diaphragm. Since these patients require prolonged artificial respiration, the iron lung or chest respirator is indicated. In sharp contrast are those with involvement of the X cranial nerve and the vital centers, the bulbar type. A tank respirator may be fatal since their principal need is to maintain a clear airway from the oropharynx to the alveoli. Intravenous fluids, oxygen and adequate elimination of carbon dioxide must be assured. A tracheotomy may be required particularly when the respiratory center is directly involved. The third and least common type is the bulbospinal which may combine the difficulty of swallowing and maintaining a free airway with a deficient peripheral respiratory apparatus. These patients often require both a tracheotomy and artificial respiration as well as appropriate supportive measures. The reader is referred to an excellent monograph for important details of treatment.[9]

SAVE LIMB[10]: So much has been written about the orthopaedic care of the after effects that only a brief summary can be given here. When the severity and distribution of the paralysis are sufficient to require prolonged treatment, a long term, team-of-specialists approach is required. The fundamentals are straight forward, the methods are several, but above all patience, attention to details, and considerable common sense are required. There is no magic wonder drug to cure severe paralysis but tested orthopaedic principles applied early, consistently, and for as long as necessary will produce heartening results. During convalescence the emphasis is upon facilitating the natural recovery process by avoiding fatigue of weakened muscles and preventing secondary changes in the involved segments which

lead to soft tissue contractures and ultimately to bony deformity. More crippling results from skeletal distortion than from paralysis alone. The chronic or residual stage marks the limit of most spontaneous return of muscle power but is by no means static. Since most paralytic polio still occurs under fifteen years of age, deformities can become serious during growth and appropriate supportive measures must be used. For severe paralysis of various muscles, much improved functional use can be supplied by splints, braces and assistive apparatus. Many patients are eligible for surgical procedures which can provide stability of weight bearing joints and replace lost functions, especially in the hand and foot.

Comment

For those with paralysis the goal is to help the individual be as nearly normal as possible with (1) the least amount of apparatus and (2) the least amount of surgery. With adequate motivation the great majority of polios can become functionally independent and able to lead full, happy lives. For future generations the vaccine is expected to eliminate the deaths and the relatively small number of "victims" of polio who are helpless cripples. Perhaps the 1954 Salk vaccine will do the trick both statistically and individually. If not, improvements and modifications are already under way in animal experiments and the answer must come, as safe and sure as that to smallpox.

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The Diagnosis and Antibiotic Therapy of Subacute Bacterial Endocarditis

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Laboratory Aspects

It is a well established fact that more than 90 per cent of cases of subacute bacterial endocarditis are due to streptococci which are green-producing or indifferent as characterized by their growth on blood agar. This group includes a number of species, the most common of which are Streptococcus salivarius, Streptococcus mitis and Streptococcus faecalis. The first two species are relatively sensitive to penicillin and do not easily become resistant to it; however, Streptococcus faecalis is considerably more resistant than the others. Not infrequently infection may be caused by streptococci that are fastidious in their cultural requirement. These organisms may be micro- aerophilic or anaerobic. They are often pleomorphic in the primary culture.

Other bacteria that are known to cause subacute bacterial endocarditis include Hemophilus influenzae, Hemophilus parainfluenzae, Brucella, Neisseria gonorrhoeae, Micrococcus, and Erysipelothrix. Even fungi have been known to produce the disease. Histoplasma capsulatum and species of Candida have been isolated. On occasion the disease may be caused by two kinds of bacteria. Success in isolating the causative organisms in cases that are suspected to be polymicrobic depends on making repeated cultures on different media. It is important to emphasize that the clinical course of endocarditis caused by infection with Brucella, Micrococcus or Streptococcus organisms may be indistinguishable; but the chemotherapeutic agents to which each species of organism responds may be quite different. Therefore, the laboratory aspects of the problem hold the key to the successful use of antibiotics. Different strains of the same species may have widely varying

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sensitivities to the antibiotic agents, and it is therefore essential to successful therapy to know the sensitivity of the specific offending organism.

The most effective method of testing sensitivity of the organism isolated is the plate dilution test[1]. This test utilizes a series of blood-agar plates in which two-fold dilutions of an antibiotic are incorporated, together with a control plate containing no antibiotic. The technician divides each plate into sectors by marking on the back with a grease pencil and numbering the sectors. This allows study of as many as six different organisms on one set of plates. Freshly grown cultures of the organism in question are diluted to a turbidity just visible to the eye, and a loopful of this dilution is spread over the appropriate sector of each plate. The plates are inspected for bacterial growth after 16 hours of incubation, or whenever organisms have grown well on the plate that contains no antibiotic. A record is made of the lowest concentration of antibiotic at which macroscopic growth of each organism is completely inhibited. A standard strain of bacteria of known sensitivity is inoculated on the first sector of each plate; any significant variation in the end point of growth of this standard strain indicates that the plates were improperly prepared, and they are discarded. Control of each test in this fashion is of considerable value, because errors in determining sensitivity will affect the clinician's choice of antibiotics and, therefore, the welfare of the patient. Use of a solid medium also allows recognition of that circumstance when the vast majority of organisms in a culture are sensitive, yet a few organisms in the culture are resistant. It is important that tests of sensitivity be performed in a uniform manner. A heavy inoculin of bacteria or increase in the time of incubation will affect the result and cause an organism to appear more resistant than it actually is. Such care is particularly important in tests involving aureomycin and terramycin. Since aureomycin is relatively unstable when in solution, plates containing this antibiotic must be prepared just before use and incubation of such plates must not be prolonged. Antibiotics in pure form must be utilized in the tests for susceptibility. Preparations of antibiotics made for intravenous injection are usually satisfactory for this purpose, whereas those for oral use are not. If such pure preparations are not freely available, they usually can be obtained directly from the manufacturer. Stock solutions of standard antibiotics for the test can be kept for some time if well frozen.

Clinical Aspects

Since most cases of subacute bacterial endocarditis are caused by Streptococcus salivarius or Streptococcus mitis, both of which are sensitive to penicillin, this is the antibiotic of choice in the treatment of endocarditis due to these organisms. In spite of the fact that many strains of Streptococcus faecalis are relatively resistant, many are sufficiently sensitive to justify expectation of occasional satisfactory clinical results when relatively large doses of penicillin are employed. It is not uncommon to find a strain of Streptococcus faecalis whose growth is inhibited by a concentration of penicillin of 3.2 units per cubic centimeter. Likewise, the micro-aerophilic streptococci are reasonably sensitive to penicillin. The studies of Hunter[2] clearly emphasized that there was a real advantage in combining streptomycin with penicillin in the treatment of subacute bacterial endocarditis owing to Streptococcus salivarius or Streptococcus mitis. This method has made possible a satisfactory clinical cure in two weeks of treatment, rather than four to six weeks of treatment as was formerly required when the usual dose of penicillin was used alone. Likewise, Hunter's method has been found effective in the treatment of subacute bacterial endocarditis owing to Streptococcus faecalis if the combination of penicillin and streptomycin in proper doses is continued over a prolonged period of time.

Two methods for the administration of penicillin combined with streptomycin are available to the clinician. 1. The desired daily amount of penicillin is administered by means of the intravenous drip method and the desired amount of streptomycin is administered twice daily by the intramuscular route. In the treatment of bacterial endocarditis due to Streptococcus salivarius or Streptococcus mitis, which are sensitive in a range varying between 0.01 and 0.1 units per cubic centimeter, it is seldom necessary to use more than 2,000,000 units of penicillin daily by the intravenous route, and 1 gm. of streptomycin given simultaneously twice daily by the intramuscular route. This dose is continued for two weeks. If the endocarditis is due to Streptococcus faecalis, the intravenous drip is the method of choice for the administration of penicillin. Five to ten million units of

penicillin is administered by the intravenous drip. The patient also receives an intramuscular injection of 1 gm. of dihydrostreptomycin morning and evening for two weeks. After the second week the dose of dihydrostreptomycin is reduced to 0.5 gm. twice daily, and the treatment is continued for four to six weeks. 2. The second method consists of the simultaneous administration of penicillin and streptomycin by means of single intramuscular injections. With this method the patient receives in a single syringe 1,000,000 units of procaine penicillin and 1 gm. of dihydrostreptomycin every twelve hours. This method is eminently satisfactory in the treatment of endocarditis owing to Streptococcus salivarius or Streptococcus mitis. However, this method is not recommended in the treatment of subacute bacterial endocarditis owing to Streptococcus faecalis.

As has already been indicated, a number of species of bacteria other than the commonly encountered streptococci may produce subacute bacterial endocarditis. Selection of the proper antibiotic for eradication of these various organisms is of extreme importance. Infections caused by Hemophilus influenzae or Hemophilus parainfluenzae should be treated with terramycin or aureomycin administered orally in combination with dihydrostreptomycin administered intramuscularly. Combined therapy is the method of choice in the treatment of endocarditis due to Brucella abortus, Brucella suis or Brucella melitensis. The most effective combination is terramycin or aureomycin with dihydrostreptomycin. In the treatment of endocarditis produced by Neisseria gonorrhoeae, Micrococcus or Erysipelothrix, adequate doses of penicillin should result in a satisfactory clinical response. Unfortunately, infections owing to Histoplasma capsulatum and various species of Candida do not respond to antibiotic therapy, and the use of even enormous amounts of antibiotics is not likely to be followed by gratifying results.

Quantitative determination of antibiotics in the blood during the course of treatment is helpful but not entirely necessary. As already indicated, if the organism is sensitive, it is seldom necessary to use more than 2 million units of penicillin daily. Values for penicillin in the blood are increased by approximately 1 unit per cubic centimeter for every increase of 1 million units in the amount of penicillin administered per twenty-four hours. This approximate relationship holds true for a total dosage as high as 10,000,000 units per day. The problem of measuring values for antibiotics in the blood of patients who are receiving multiple antibiotics is difficult and requires considerable aid from the laboratory.

Blocking Agents

There can be little doubt that the use of so-called blocking agents to enhance the effect of antibiotics is of some importance in the management of subacute bacterial endocarditis, but in my opinion the use of carinamide or probenecid (benemid) has not been essential often to successful therapy. Carinamide is a sulfonamide compound. The doses of this drug are relatively enormous, and the results of its administration are somewhat questionable. Probenecid is undoubtedly the blocking agent of choice at the present time. The recommended dose of this latter drug is 0.5 gm. administered four times daily by the oral route. I have found that, if values for penicillin in the blood are low, administration of probenecid definitely will increase the level, perhaps twofold or even more. On the other hand, when a fairly high value for penicillin in the blood already exists, the use of probenecid may increase this level slightly, perhaps as much as 2 units per cubic centimeter of blood, but it will not increase it twofold. Fortunately, probenecid does not inhibit the excretion of streptomycin, and therefore it can be administered without fear of accumulating toxic values of streptomycin in the blood while trying to obtain an increase in the value for penicillin.

In some situations the proper antibiotic has been selected, adequate values in the blood have been obtained and the patient has been treated for an adequate length of time, but still the treatment in subacute bacterial endocarditis fails. Too often, failure has been attributed to lack of effectiveness of the antibiotic. Admittedly, some organisms may be resistant or may become resistant to the antibiotic, and this in itself may account for failure, regardless of whether small or enormous amounts of antibiotic are used. Furthermore, many so-called relapses or recurrences are not relapses but examples of reinfection. There are other reasons for failure in the treatment of subacute bacterial endocarditis aside from failure of the antibiotic or the development of resistance. Those who have treated this disease are aware of the fact that not infrequently a patient apparently may be doing well, cul-

tures of the blood may be sterile, and progress appears to be satisfactory; but suddenly the patient dies. Occasionally, no reason for this catastrophic ending can be discovered; however, not infrequently evidence may be found of myocarditis, even in the absence of bacteria in the blood stream or on the cardiac valves. Another cause of failure during the course of what appears to be successful treatment is the presence of embolic phenomena or the rupture of a mycotic aneurysm. The embolic processes may be small and insignificant but, nevertheless, fatal. Still another cause of unsuccessful treatment is the onset of congestive heart failure when all seems to be going well. There is no way to prevent any of these several complications; they can only be treated as they occur.

Febrile Reactions

Another interesting and often misleading phenomenon may be observed during administration of antibiotics to patients with subacute bacterial endocarditis. This consists of a persistent or a newly developed febrile reaction in the course of what appears to be successful treatment. In other words, the offending organisms apparently have been eradicated, but the patient has fever. This situation poses a real problem for the clinician, who must decide whatever he should continue therapy, increase the amount of antibiotic, or discontinue its administration. Admittedly, penicillin, as it is prepared today, is relatively free of pyrogens; however, when enormous doses of penicillin are used, enough pyrogens may be administered to produce "drug fever." If repeated sterile cultures have been observed, yet the patient continues to experience chills or fever, discontinuance of therapy altogether has often been followed by return of the temperature to normal and recovery of the patient. If it is necessary to continue treatment after this, depot penicillin may be used. Likewise, antibiotics other than penicillin may, on rare occasions, be responsible for drug fever. Finally, fever not caused by infection may occasionally result from a reaction caused by pyrogens in the rubber tubing of the set utilized for intravenous therapy. This is important only when the method of intravenous drip is used for administration of the antibiotics. This reaction can best be avoided by the use of pure rubber tubing.

If a suitable antibiotic or combination of antibiotics is selected and if the dose and duration of treatment are adequate, from 70 to 80 per cent of patients with subacute bacterial endocarditis should recover. When recovery occurs, the physician should remember, however, that these patients have damaged heart valves. The activities of these persons must be limited to a degree commensurate with the extent of irreversible cardiac damage that has occurred.

Prophylaxis

Prophylaxis of subacute bacterial endocarditis should be mentioned. The best way to control this disease is to prevent its development. Obviously, no patient who has previously recovered from bacterial endocarditis should have any operative procedure performed without prophylactic antibiotic therapy. This may consist of administration of penicillin for a day or two before and again after the operation, or perhaps aureomycin or terramycin may be given orally during this period. Furthermore, it is my conviction that no patient who has a cardiac murmur should undergo oral, colonic, rectal, or transurethral operative procedures without the benefit of prophylaxis with antibiotics. Prophylaxis of this type is equally essential for patients who are to undergo operative procedures on the heart or great vessels for such lesions as patent ductus arteriosus, coarctation of the aorta, and valvular deformities.

Summary

Adequate laboratory facilities are essential in the diagnosis of subacute bacterial endocarditis. Likewise, sensitivity studies of organisms isolated in this disease are essential in the effective treatment. If the proper antibiotic or combination of antibiotics is administered in adequate doses, satisfactory clinical results should be obtained in 70 to 80 per cent of patients suffering with this disease.

The preoperatvie prophylactic use of antibiotics in patients with preexisting heart murmurs will prevent the development of many cases of subacute bacterial endocarditis.

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The Pyloric Antrum, A Diagnostic Enigma*

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The pyloric antrum, the distal 2.5 cm. of the stomach adjacent to the pyloric sphincter, is of extraordinary interest to both the diagnostician and pathologist, for it may be the site of the most baffling abnormalities. The antrum of the stomach is one of the easiest portions of the stomach to visualize by x-ray, but the most difficult to analyze from the differential diagnostic viewpoint. It has been stated by Jensen and Rivers (5) that in antral lesions one cannot be certain from non-operative methods of diagnosis that one is not dealing with malignancy in about 15% of cases. Alexander (1) reports that 40% of lesions in the prepyloric region are malignant. It is also common knowledge that the majority of benign and malignant gastric tumors are located in the pars pylorica of the stomach. Conditions in this region which may produce subjective symptoms, objective signs, or both, may be due to one or more of the following variations: (1) normal change in size of the rugae; (2) pylorospasm, (3) gastritis; (4) benign pyloric hypertrophy; (5) gastric ulcer; (6) carcinoma; (7) benign tumors; (8) lymphosarcoma; (9) syphilis; and (10) tuberculosis. For practical purposes, however, the differential diagnosis usually lies between carcinoma, benign ulcer, and such benign lesions as antral gastritis and pylorospasm.

Pylorospasm

The normal function of the pyloris involves powerful contractions and a certain degree of relaxation of a strong muscular ring. The pyloris is notoriously a prominent effector zone for impulses arising from the hypothalamus, its contractions reflecting nervous states and emotional traumas. This is frequently demonstrated by the symptoms of pylorospasm; "the lump in the stomach," nausea, and vomiting. These contractions may be excessive, and when sufficiently great and enduring, may be habitual, resulting in symptoms which simulate ulcer or neoplasm.

The roentgenological findings are often indistinguishable from those of an organic lesion. Gastroscopic visualization may reveal a completely normal mucosa, but leave the suspicion of an intramural lesion. Jordon and Lahey (10) report that a certain number of such cases have no abnormality discernable to the eye and the hand of the surgeon, the rest being divided among (1) those having thickened muscularis; (2) those with definite gastritis; (3) those with a small mucosal ulcer with or without gastritis; and (4) those with a malignant lesion, usually an infiltrating carcinoma. Under such circumstances, Jordon and Lahey (10) also feel that there should be no regret for an exploration which shows either no pathological condition in the stomach, or a thickened muscularis.

Causes of prepyloric spasm extrinsic to the antrum itself must be sought in all cases in which no local reason is found. An ulcer elsewhere in the stomach, particularly one of the posterior wall near the lesser curvature, may produce such gastric irritation that habitual pyloric and prepyloric spasm occurs. Such ulcers are extremely difficult to visualize, especially the shallow ones. Completely extragastric conditions such as: recurrent appendicitis, gall bladder disease, colonic dysfunction, and even conditions outside the gastrointestinal tract, notably; renal calculi, migraine, and cardiac disease may produce temporary or habitual pylorospasm.

Ulceration

It is now universally accepted that the differentiation between benign and malignant ulceration in this area cannot always be accurately made by means of the roentgen examination alone. Carcinoma of the antrum may simulate benign lesions clinically and may show a considerable amount of relief following the use of medical ulcer therapy. In benign ulceration there are certain factors which complicate the roentgenological picture and in many cases cloud the diagnosis. The chief offender is, probably, spasm as described above. The antral lumen may be of small diameter and elongated which, all too frequently, causes difficulty in demonstrating a niche. In the absence of a niche a diagnosis of benign ulcer cannot be made. Aid in differentiation may be expected from the

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gastroscopic examination but, heretofore, detailed visualization of this area has not been without difficulty. Ulcers in the antrum, if treated medically, must be regularly and frequently checked. If there is not a prompt and substantial disappearance of the lesion, resection should be advised. Daub (3) reported thirty-five cases of ulcerative lesions at or near the pyloris for which resection was performed. Twenty per cent of these were malignant. It must, therefore, be assumed that any prepyloric ulcer or deformity is actually malignant or potentially malignant until proved otherwise.

Bands and Adhesions

Prepyloric deformities due to adhesions and bands, which roentgenologically are compatible with deformities by malignant gastric pathology have been reported by Jenkinson, Pfisterer, Norman, and Latteier (9). Causes of such deformities were: (1) pressure by the falciform ligament, (2) short gastro-hepatic ligament causing traction on the lesser curvature, (3) adhesions to the omentum and stomach, (4) gall bladder adhesions, (5) perigastric fibrosis secondary to chronic ulceration of the duodenum. Seven of their cases (11) had signs of gastro-intestinal bleeding and all but two had achlorhydria. In all these cases a barium enema was negative. Sahler and Hampton (11) reported bleeding as the most common constant symptom in extramucosal tumors of the stomach.

Syphilis

Syphilis of the stomach, which is quite uncommon, is often mistaken for carcinoma. The term "Syphilis of the Stomach" is applied to the lesion that occurs in the tertiary stage of the disease. It is estimated (Bockus) that in the United States 0.3% of patients with syphilis have involvement of the stomach. The roentgen defect occurs in the antral region in 70% of the cases. In the majority of cases reported in the literature, the diagnosis was made clinically. The usually accepted criteria for the clinical diagnosis of gastric syphilis include: untreated syphilis, a demonstrable roentgen defect, and the presence of gastric symptoms. In addition the inability to alleviate symptoms or effect any improvement in the anatomic, x-ray defect by orthodox methods of management without antisyphilitic therapy, and symptomatic relief with disappearance of the x-ray defect after intensive specific therapy are of prime importance. In cases of severe scarring a persistent defect after treatment and the presence of obstruction may make surgery a necessity. Gastroscopic examination in syphilitic lesions usually reveals nothing specific.

Tuberculosis

Tuberculous involvement of the stomach is a rare condition, but is important clinically because, in the absence of active pulmonary or systemic tuberculosis, it may be curable by gastric resection. As is frequently shown by case histories quoted in the literature, it is obvious that gastric tuberculosis mimics gastritis, peptic ulcer, and gastric carcinoma. The usual symptoms are pain after meals, epigastric discomfort, vomiting and loss of weight. Fifty per cent of the reported cases (6) have a palpable mass while 50% show other evidence of tuberculous infection. There is no characteristic roentgenological appearance of gastric tuberculosis. The findings suggest any one of the diseases which it mimics. Tuberculosis and carcinoma are associated in a high percentage of cases (6). The simultaneous involvement of the stomach and duodenum increases the possibility of a tuberculous etiology.

A correlation of the history, physical examination, and roentgen findings must be made, since a definite diagnosis cannot be established by roentgenological examination alone. One should be suspicious of gastric tuberculosis in a young patient who has a demonstrable lesion in the gastric antrum which has not responded to conservative management and who has, in addition, one or a combination of the following findings: tuberculous infection elsewhere in the body, a strongly positive tuberculin reaction in the absence of demonstrable tuberculosis in other organs, a palpable abdominal mass, roentgenologic evidence of a fistula or sinus, or involvement of the stomach and duodenum simultaneously with contiguity of the lesions. Gaines, Steinbach, and Lowenhaupt (6) suggest a therapeutic test of streptomycin in adequate dosage for a period of at least three weeks in patients who are suspected of having gastric tuberculosis and who have not responded to the routine treatment for a peptic ulcer.

Gastritis

Antral gastritis is an inflammation of the antrum of unknown etiology, which probably begins in the mucosa, usually involves the submucosa, and may even

extend to the serosa (2). This condition must always be considered in the differential diagnosis of lesions in the antral region. Most cases of antral gastritis have been in males from forty to seventy years of age. The majority of patients show hyperacidity, but this is not as marked as in peptic ulcer cases. Berg (2) reported a few cases with achlorhydria. In a series of cases analyzed by Benedict (6), hemorrhage occurred in 19.7%. The clinical picture of antral gastritis is not definite enough to justify its diagnosis on this basis alone. With treatment there is considerable symptomatic improvement, but little change in roentgen findings. It is difficult to differentiate antral gastritis from other lesions that occur in this area, such as: prepyloric ulcer, hypertrophy of the pylorus, and carcinoma. From a roentgenological standpoint, some cases which appear as typical of antral gastritis may prove at operation to be carcinoma. Gastroscopic examination is of great aid and may indicate the diagnosis. In order to prevent needless surgery, every effort should be made to differentiate antral gastritis from carcinoma. Gastric resection must be performed in cases where the diagnosis remains doubtful.

Summary

(1) Deformities involving only the walls of the stomach, even though present at repeated examinations and resistant to antispasmodics, may be due to spasm.

(2) The importance of an early diagnosis of carcinoma of the stomach makes necessary the careful evaluation of any changes occurring in the pyloric antrum. The cause of these variations may be difficult to determine by x-ray, gastroscopic, laboratory, or clinical study. Incorrect interpretation can lead to errors in the application of correct therapy. If these methods fail to rule out malignancy, then surgery is indicated if only as a further diagnostic procedure.

(3) Patients with persistent lesions should have exploration and resection. The reasons are obvious in cases having carcinoma. In cases with unhealed, chronic gastritis, or a shallow, unhealed ulcer, resection is advocated because of the malignant potentiality of the lesion.

(4) Jordon and Lahey (10) feel that in the presence of even an uncertain lesion in the antrum, where malignancy is so prevalent, an aggressive and radical approach is well justified. The low operative mortality figures are additional support of this viewpoint.

(5) It is much more prudent to explore surgically all patients with persistent roentgenological defects and find nothing than to risk the hopelessness of an inoperable malignancy at a later date.

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A "new look" consisting of improved typographical effects can be noted in the current and forthcoming issues of the "New England Journal of Medicine," recognized as a leading medical publication in this country. The new trend is in keeping with the Journal's expanding circulation which has increased from 13,000 in 1943 to 29,000 in March of this year, according to recent subscription figures.

The Aero Medical Association has established the Louis Hopewell Bauer lectureship in honor of the association's first president, it was recently announced at a dinner concluding the annual meeting of the association held in Washington, D. C. Dr. Bauer is secretary-general of the World Medical Association and was the 1952-53 president of the American Medical Association.

Case Report of Boric Acid Poisoning from Topical Application*

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For the last fifty years cases of boric acid poisoning have been reported in medical literature. Unfortunately, the general public, and even members of the medical profession do not realize the potential danger of this apparently useless drug. In fact, one of the loose leaf systems of pediatrics recommends boric powder for the treatment of Ritter's disease, a procedure which is a dangerous one.

The drug is widely used, being found in many commercial dusting powders, and ointments which are frequently used on infants. Many eye washes, lubricating jellies, contraceptive jellies, and even embalming fluids contain boron. The drug is in no way bactericidal.[1]

Boric acid poisoning has occurred by ingestion,[2] by irrigation of body cavities,[3] by intravenous infusions. There have been numerous reports of fatal poisoning from application of boric acid powder, ointment or solution to the skin.[4,5,6,7]

Although the drug is not absorbed from the intact skin,[8,6] it is readily absorbed from any area of broken or eroded skin.

Poisoning from boric acid is probably more common than is generally realized. Goldbloom and Goldbloom recently reported on 109 cases of boric acid poisoning, and Ducey and Williams reported three additional cases. In the Goldblooms' cases the fatality rate was 55 per cent for the whole series, while it was 70.2 per cent for children under one year of age.

The most common symptoms of poisoning in infants are vomiting, diarrhea, convulsions, and coma. An erythematous rash is also characteristic. This erythema may be so intense as to make the infant have an appearance of a "boiled lobster" as Watson described his fatal case. The skin later may be covered with bullae. Probably many cases of Ritter's disease are actually boric acid poisoning.

Report of Case

The following is a case report of a fatality due to the use of boric acid powder and solution. The seventeen day old infant was admitted to the St. Joseph Hospital, Lexington, March 12, 1953.

The parents brought the baby in because of its rash and vomiting. As the baby was deep crimson from its feet to its scalp, the mother was asked if she had used any boric acid on the baby. She gave the following history: Four days before admission the baby began to have loose stools, and his buttocks became chafed. For two days she powdered his perineal region with boric acid powder, and on the third day she substituted boric acid solution for the powder. On the day of admission she noticed that the skin over his entire body was quite red, and a large blister appeared on his neck. He also had fever and vomited several times.

On examination, the baby was crimson over the entire body except his scalp. He had a large ruptured vesicle on his neck. There was considerable excoriation in the perineal region with a raw weeping surface. The mucous membranes were red, the lungs were clear, the heart apparently normal. The abdomen was distended. He held himself in a position of opisthotonus. He had fibrillary twitchings of his facial muscles.

The baby was moderately dehydrated and was given parenteral fluids, and penicillin as a prophylaxis for secondary infection. He continued to vomit and retained nothing orally. He had frequent stools, but they were not diarrheal in character. Both the stools and vomitus had a gray color, especially the vomitus.

In the course of some twelve hours the brilliant crimson of his skin began to fade, and many large bullae formed. The slightest pressure of his skin would cause the epidermis to slough off.

The baby was wrapped in petroleum gauze, given intravenous fluids, cortisone, and one blood transfusion. His course was steadily down hill, and he became comatose and died the third hospital day. By the time of his death approximately half of his epidermis had sloughed off.

His temperature was 102.4 on admission and he had a moderate fever until he expired.

His blood count showed: RBC 4,700,000, Hemoglobin 14.6 grams, WBC 17,700, Seg-

*Read before the Fayette County Medical Society, April, 1953.

mented Neutrophiles 32 per cent, Bands 11 per cent, Lymphocytes 52 per cent, Monocytes 5 per cent. Urinalysis showed: Albumin, negative, Sugar, negative, Acetone, negative. Few epithelial cells and uric acid crystals.

The first urine specimen he passed was tested for boric acid and it gave a strongly positive reaction. All tests for boric acid were performed by Dr. William F. Wagner, Department of Chemistry, University of Kentucky. He used turmeric paper and the spectroscope to identify the boric acid.

Autopsy Report

Gross:

The body was that of a well developed male infant appearing the stated age of seventeen days. There was marked loosening of the epithelium with some large blisters which sloughed off at the slightest touch. At the end of the examination the skin was practically all removed from the body.

The penis was swollen and excoriated.

The fontanelles were depressed.

The liver was enlarged, weighing 156 grams.

The peritoneal cavity was not unusual.

The small intestines were distended with gas.

The pancreas, adrenals, spleen and kidneys showed no gross lesions.

There was mild congestion in the lungs.

The heart and large vessels showed no lesions.

Histopathology:

Sections from the heart show the myocardial cells to be indistinct. The borders are indefinite and the muscle cells are definitely cloudy, and in areas granular. The nuclei are somewhat prominent and seem to be surrounded by a small halo.

The blood spaces are somewhat distended.

The lungs show moderate atalectasis and edema, and in areas extravasation of blood into the alveolar spaces and beneath the pleura.

Some of the bronchioles contain thick mucous, but little evidence of inflammation could be demonstrated in the pulmonary tissue. The liver cells are large and definitely cloudy, but no other abnormalities could be detected. No abnormalities could be detected in the pancreas. The island and acinar structures are essentially normal. No abnormalities could be seen in sections of the esophagus. The adrenals are not unusual. The spleen shows no lesions.

In the kidneys there is a definite swelling of the tubular epithelium which all but completely occludes the lumen of these structures. The glomeruli are not remarkable.

Sections from the small and large intestines show the mucosal cells to be rather large and there is marked exfoliation of these cells. Many of the individual cells are hydropic and many are distended with mucus.

Sections of the skin show edema in the corium. The epithelium is very thin, with only the basel layer remaining in many areas. The epithelial papillae are largely destroyed. The inflammatory reaction is minimal.

Summary of Autopsy Findings:

Extensive large scaly bullous lesions in the skin with almost complete excoriation of the skin.

Excoriation around the anus and perineal region and most of the mouth.

Pulmonary atalestasis.

Pulmonary congestion.

Marked cloudy swelling in the liver.

Cloudy swelling in epithelial cells lining the renal tubules.

Edema and hydropic degeneration in epithelium of the gastro-intestinal tract, with marked exfoliation of the cells.

Boric acid was demonstrated in the liver tissue by Dr. William F. Wagner, Department of Chemistry, University of Kentucky.

Summary

A case is reported of a 17 day old baby who died of boron poisoning from the use of boric acid powder and solution which was applied to his excoriated buttocks.

It is suggested that a warning label be put on all commercial preparations that contain boric acid, such as dusting powder and ointments.

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Carcinoma of the Cervix*

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Carcinoma of the cervix is a killing disease. Annually 22,000 women die from its devastating effects and it has been estimated that for each one that dies there are nine others who have cancer in its incipiency. This is a great challenge. In the early stages cancer is treated with enthusiasm and hope, but in the later stages the outlook is gloomy, depressing, and far too often hopeless.

From 1939 to 1951 there were 498 cases of carcinoma of the cervix diagnosed at the Louisville General Hospital. We will discuss some of our personal experiences in handling these cases, the author having seen most of them at one time or another in the process of their treatment.

The average length of time from the onset of symptoms to the institution of treatment was eleven months. The delay in diagnosis was due to superstition, procrastination and ignorance, together with the fear of facing facts. Which is worse on the part of the patient, her fear or her procrastination? The physician is not without his share of responsibility.

Symptoms

The chief complaints and their frequency were as follows:

1. Bleeding	211
2. Excessive vaginal discharge	124
3. Urinary frequency	90
4. Combinations of 1, 2, and 3	40
5. Anemia	33

The appearance of any of these symptoms can be detected by all of us if we are conscious of their importance. Many women believe that when they have irregular bleeding at middle age it is the "change of life" and are content to do nothing about it or use it as an excuse to avoid facing facts. Some of these cases had bled for over two years without treatment because they thought it to be the menopause, which many use as an escape mechanism. Prolonged, excessive and irregular bleeding is not a symptom of the menopause but denotes something wrong in the uterus. When irregular or prolonged bleeding occurs at middle age or after the menopause, 83 times out of 100 cases it means organic changes in the uterus, 62 per cent of which are usually cancer.

Excessive vaginal discharge is a most common symptom, and because it is a common complaint, the change in the type or amount of discharge is not noticed. When the discharge becomes watery or malodorous it is significant, and when stained by blood it is of great importance. At first it is not necessarily itchy or irritating.

Urinary frequency may be the result of many things, such as infection, changes in the bladder from involvement, and numerous other conditions. These are tolerated for months without relief or investigation.

Secondary anemia was present in one-third of the cases, and was very severe as a result of the wear and tear on the blood-forming system from the cancer, infection, etc. Some had taken treatment for "anemia" without any attempt being made to find and treat its cause.

Many people believe that they must have pain before it can be cancer. Pain is not a symptom of cancer, but is the result of extension of the process into the adjoining tissues, with distortion and involvement of normal function. This is present after the growth has broken out of its bounds and spread, or metastasis has occurred.

Cancer is no respector of race, creed, or person. It is a disease of rapidly diminishing returns, and if the physician and patient become aware of this, their cooperation will bring better results.

The delay is not all due to the procrastination of the patient. Douches, paints, sprays, "blue lights," and "shots" are some of the reasons for delaying vaginal examination and biopsy of the lesion to make the diagnosis. Early thorough examination and early biopsy of suspected lesions is the only way to make an early diagnosis of cancer.

The ages of the patients in this study ranged from seventeen to seventy-nine, with the highest incidence between the fourth and sixth decades. There was a slight predominance of white (273) over colored (225), but the "chi-square test" indicates that the difference in age dis-

*A 21 year study of cases admitted to the Louisville General Hospital. The study was made possible by grant from the Kentucky Cancer Society.

tribution between the two groups of cases is entirely due to chance.

The distribution of these cases as to parity and survival show that there is no significant difference in the gravid and nulliparous in the five-year survival group, or in those who died within the five-year period. The range of parity extended from no children to sixteen or more, and the survival rate in all cases treated was 24.7 per cent for five years.

Diagnostic Classification

The diagnoses were made only on the pathological diagnosis, and were classified according to the international classification of carcinoma of the cervix. Cases without pathological diagnosis were not included in this study.

Stage I - 45 cases (11.5 per cent chance; 80-100 per cent five year arrest)

Stage II - 56 cases

Stage III - 66 cases (156 were hopeless when first seen)

Stage IV - 90 cases

Total cases - 257

Two hundred and forty-one cases were not classified as to stage because they were too advanced when first seen to classify into late stages. This makes a total of 498 cases. In the extensive lesions in stage III and IV, we were unable to differentiate between them. Of the 498 cases, 29 were adenocarcinoma of the cervix. These were usually far advanced when first seen.

Examination at the time of admission revealed that 455 of the 498 cases had erosion of the cervix and a mass. Two hundred and thirty-eight cases were shown to have extension in the sides of the pelvis, which placed them in Groups III and IV, and made the prognosis hopeless. The result expected from treatment of these stages is only palliative.

Treatment Outline

A general outline of the treatment of cancer of the cervix in the Louisville General Hospital as carried out by the Department of Obstetrics and Gynecology and the Department of Radiology is briefly as follows:

Upon admission an examination is made of the patient and a biopsy is taken of any suspicious lesion (multiple biopsies are frequently taken). The patient is then cleared through the Departments of X-ray, Urology, and Medicine, and is told to return to the Clinic in one week. At this time, if the diagnosis of malignancy is confirmed, treatment is outlined to begin as soon as the appraisal of the patient and lesion is completed.

The following outline is being used now, depending upon the lesion found, its classification, and the patient's condition.

1. Carcinoma in situ—total hysterectomy with conservation of ovaries if under 40 years of age. (No radiation)
2. Stage I
   a. 4500 mgm. hours of radium to the cervix followed by radical hysterrectomy and gland dissection in six weeks.
   b. Poor surgical risks: Deep X-ray therapy and radium (6000-9000 r. units — 4500-6000 mgm. average) and careful observation.
3. Stage II—Deep X-Ray therapy to cervix and pelvis followed by radium. If refractive to treatment, surgery if possible.
4. Stage III—Deep X-Ray therapy to cervix and pelvis followed by radium as indicated by response.
5. Stage IV—Deep X-Ray therapy followed by radium only as a palliative procedure. No treatment is given to those who when first seen have vesicovaginal fistula.

Carcinoma of the cervix associated with pregnancy is studied carefully and treated, depending on the viability of the fetus, the stage of the cancer and the operability of the patient. If the fetus is not viable, the uterus is usually emptied, and the patient treated in one of the above manners, depending on the stage of the lesion. Cancer is a killing disease and there is no need of losing both mother and child. Approximately 27 per cent of those children who are born after the mother has been treated for cancer are deformed.

Follow-up Study

The clinical follow-up is very careful, as follows:

a. Weekly or monthly visits for the first four months.

b. Bi-monthly visits for the next four months, if condition is satisfactory.

c. Examination every four months for two and a half years.

d. Examination every six months thereafter.

These cases are studied by the Depart-

ment of Gynecology and advised by the Tumor Clinic of the Louisville General Hospital. This is essential for good results, but in spite of such detailed and exacting treatment and follow-up, only 24.7 per cent have a five year arrest.

With this general outline as to treatment, we have divided the cases we have seen into groups from 1929 to 1939, and, from 1940 to 1951, for the sake of comparison and study.

PRIMARY TREATMENT AND SURVIVAL (FIVE YEARS)

	1929-1939	1940-1951
Radium	56 (average 4423 mgm.)	39 (average 3853 mgm.)
X-Ray Therapy	12 (average 3.838 r.u.)	29 (average 6.224 r.u.)

As we know from the standpoint of arresting the disease, surgery and radiation are the main weapons against the localized disease. When the parametrial spread is present, X-Ray therapy may cover it. No carcinoma should be treated with either of these elements unless the person giving the treatment is thoroughly familiar with its use, effect and results.

Since over-treatment is often as fatal as under-treatment, all attention should be given with the greatest of care, supervision and precaution. Surgery can be effective in the early stages and in some radium resistant carcinomas. Here again, the surgeon should be as competent in his field as the radiologist is in his, and like the well-trained radiologist, there are too few competent radical cancer surgeons.

No one kind of treatment or combination of treatments is feasible or advisable for all patients. Always remember that cancer can grow under intact mucous membrane and must be sought till found and eradicated, and carefully followed thereafter.

Never be lulled into a false sense of security by a temporary improvement under any form of treatment. Cancer must be watched and carefully followed. There should be a thorough pelvic examination, both speculum examination and rectovaginal palpation, on each visit. Biopsy should be done early, if indicated.

Complications of Therapy

Some of the complications that have followed this radium and X-Ray therapy:

Bleeding	32 cases
Recto-vaginal fistula	26 cases
Vesico-vaginal fistula	10 cases
Intestinal obstruction	11 cases
Rectal stricture	7 case
Radium necrosis	8 cases

These complications are found in the advanced malignancies, about 80 per cent of which have complications which are discovered too late.

There is always a cost for a cure, and the cost of treatment of cancer and its complications in some instances is extremely high. This cost can be reduced only by early diagnosis and treatment.

With the above careful work-up and follow-up, we have as follows:

	1929-1939	1940-1951
Five-year survival	57 cases, 31.3%	45 cases, 19.5%

The over-all five-year arrest in these cases, a mean per cent of the two groups, is 24.7 per cent of all cases. Out of 498 cases treated by all indicated forms of treatment there were, after five years, 136 patients alive and arrested in Stages I or II (with an occasional Stage III).

There were 45 cases in Stage I and 102 cases in Stages I and II at the time of their admission. This is the most hopeful stage for results. The others were salvaged from Stages II and III. This cannot be explained by the difference in treatment, but on the delay and procrastination in the institution of the treatment.

To show the lack of cooperation on the part of the patient, after the diagnosis of cancer is made and treatment is partly or fully given, and the patient knows she has cancer, 130 of the 498 cases failed to report for follow-up. Unfortunately, these have to be cancelled as lost or dead.

Summary

In the past twenty-one years at the Louisville General Hospital there have been 498 cases of carcinoma of the cervix. Only 11.5 per cent of the patients had hopes of five-year arrest of the disease when first the diagnosis was made, with an over-all of 24.7 per cent five-year arrest of the disease.

In spite of all the education by the profession and cancer societies, there remains a great need for public recognition of the considerable prognostic difference between cancer treated early and cancer neglected.

The Use of Antibiotics and Antisera in the Treatment of Acute Injuries*

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I Introduction

The modern antibiotic agents and antisera are used primarily to prevent, control, or cure infection. In acute trauma, infection may develop either in inflicted wounds, in operative wounds required for the treatment of the injury, or in one of the body systems such as the respiratory and genito-urinary.

For practical purposes, it is necessary to consider that all accidental wounds or wounds of violence are contaminated by bacteria, the number being determined by the amount and type of contaminating material. Since infection is largely the result of bacterial growth upon the pablum of devitalized tissue or debris in a wound, the most important step in preventing infection is the prompt institution of surgical treatment consisting of excision of all devitalized tissue, removal of foreign bodies, hemostasis, and application of sterile dressings incorporating splints if indicated.

Antibiotics and antisera are generally used as therapeutic adjuncts to surgery in the care of the wounded and should not be expected to take the place of prompt and adequate surgical treatment. Their chief value lies in the attenuation, limitation, or control of infection by residual bacteria in wounds after debridement, or in the localization of infection developing within wounds of patients in whom surgical treatment is necessarily delayed or is not possible.

Experience has shown that these agents must be used properly to obtain their full effect. Their improper use may be followed by limited, incomplete, or absent clinical effect.

As a result of the numerous advances in the field of chemotherapy during the past ten years, the various antibiotic agents have assumed greater, and the antisera lesser, importance in the control of infections.

This discussion is intended to review the various agents which are available, the factors which define their effectiveness and limitations, and the indications, dosage, methods of administration, and limitations of their clinical use.

II Antibiotic Agents

A. General Considerations

Contrary to the current assumption of many surgeons that there is no longer any problem in the prevention or control of infections because of the wide selection of antibiotics which are available, many of the old problems persist and new ones have arisen with the introduction of each new agent. The intelligent use of antibiotics for the prophylaxis and treatment of infections in patients with acute trauma demands a consideration of the following factors: accurate and complete diagnosis of the injuries sustained, proper timing of associated surgery, selection of proper chemotherapeutic agent, adequate dosage, early treatment, method of administration, untoward symptoms, superinfections, and supportive therapy.

I. Accurate and Complete Diagnosis of Injuries

The necessity of a correct clinical diagnosis and evaluation of the patient's condition is obvious. Careful examination should be done to determine the cause, location, nature, extent, and duration of the injuries. Valuable information can be gained as to the probable types of contaminating bacteria and the existence of infection if already established. Observation may also indicate the kind of infection and whether it is localized or invasive, mild, serious, or fulminating. Immediate examination by smear and culture of exudates obtained from infected areas is recommended to give additional data on the causes of the infection.

2. Proper Timing of Associated Surgery

Remember that antibiotic agents should be used as therapeutic adjuncts to the indicated surgical procedures. If bacterial contamination only exists in the wound,

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prompt surgical excision of all of the devitalized tissue, clotted blood, and foreign bodies within 6 to 8 hours after injury is most important. Antibiotic therapy should be started before and contiued after the debridement. If bacterial infection exists, surgical excision of the infection is generally impossible. Therefore, operative procedures are usually delayed until the invasive qualities of the infection have been overcome by chemotherapy or have been limited to incision and drainage of wound abscesses or areas of necrotizing cellulitis and the removal of infected necrotic tissue, sequestra, or foreign bodies.

3. Selection of Proper Chemotherapeutic Agent

Whenever possible, the choice of the antibiotic agent for a given case should be based upon its anti-bacterial effect for the contaminating or infecting bacteria presumed to be present or shown to be present by smear or culture. The latter procedure is generally preferable when infection has already started to the blind selection of an antibacterial agent. When possible, one effective antibiotic should be used instead of a "shotgun" mixture of three or more agents. There is some evidence that antagonism may occur between antibiotics which may decrease their effectiveness.

Because of the variation in bacterial resistance by strains of the same species, sensitivity tests to the various antibiotic agents are recommended in serious or prolonged infections, whenever possible. Although not infallible, the antibiotic-impregnated disc method gives valuable information and is sufficiently simple for use in any laboratory employing a bacteriological technician.

Many strains of bacteria in our environment are gradually acquiring resistance to the antibiotics. Only 48.5 per cent of the strains of hemolytic Staphylococcus aureus were found to be sensitive to less than 10 units of penicillin per cubic centimeter last year in our laboratory.

4. Adequate Dosage

The question of dosage is still in a state of flux. The evidence indicates, however, that the dose of the antibiotic agent should be sufficiently large to produce antibacterial concentrations in the blood and intercellular fluids, and that the duration of therapy should be sufficiently long to permit the natural defensive mechanisms of the body to dispose of the inhibited but often still virulent bacteria.

The majority of agents exert only a bacteriostatic effect, which is greatest on actively growing and reproducing bacteria. Failure to continue treatment sufficiently long to permit elimination of the bacteria by the body's defenses may result in the delayed appearance or an exacerbation of an infection.

In the case of some of the antibiotics, particularly penicillin, the evidence suggests that progressively large doses have an increasingly greater antibacterial effect. An example of this is the in vivo effect of progressive doses of penicillin in experimental gas gangrene produced by highly virulent Cl. welchii.

5. Early Treatment

The earlier that antibiotic therapy is started after injury, the better. Its use may keep any infection which develops either localized, attenuated, or dormant. It must be remembered that chemotherapy may mask developing infection either within the wound or elsewhere in the body to the point that its diagnosis and localization become very difficult. In established infections, early antibiotic therapy gives a better chance of producing rapid and prompt control of the invasiveness of the process with spontaneous resolution or destruction of a minimal amount of tissue. Late treatment usually results in a more limited and delayed effect, and complications are more numerous, including local necrosis, abscess formation, or systemic invasion. Failure to recognize metastatic complications usually produces an incomplete chemotherapeutic response and prolonged morbidity or death. If the temperature and other general signs of infection do not begin to recede within 72 hours after the start of chemotherapy, the co-existence of a neighboring abscess or one or more metastatic infections is suggested.

6. Method of Administration

The systemic administration of antibiotics by the oral or parenteral routes is generally used. The local application of chemotherapeutic agents to wounds is seldom indicated in the treatment of patients with acute injuries.

In traumatic shock, the absorption of penicillin, aureomycin, chloromycetin, and terramycin may be retarded somewhat, but not prevented. However, once

effective blood concentrations are attained, they remain at high levels for longer periods of time.

7. Untoward Symptoms

Since untoward reactions may develop during therapy with any of the antibiotic agents, it is advisable for the clinician to be informed as to their nature and alert for their occurrence. He must also decide if the antibiotic agent should be discontinued and if the untoward reaction requires treatment. The toxic reactions attending the use of antibiotics are now well known. Unfortunately, however, signs of gastrointestinal irritation such as nausea, vomiting, and diarrhea may occur during treatment with aureomycin, terramycin, or chloromycetin and may make the patient very uncomfortable. This is particularly true with aureomycin and terramycin, but much less so with chloromycetin. Pruritus, stomatitis, proctitis, vaginitis, allergic skin reactions, and febrile reactions of the Herxheimer type have been noted with aureomycin or terramycin. Maculopapular cutaneous rash appearing on the fourth to seventh day and stomatitis on the fifth to eighth day have also been seen with chloromycetin. Suppression of the hemopoietic system has been described after chloromycetin therapy but has not been seen by the authors to date.

8. Superinfections

The suppression of sensitive bacteria in mixed infections by antibiotics may be followed by a marked change of the bacterial flora. Under these circumstances, bacteria which are normally of lesser virulence may become invasive occasionally and may even invade the blood stream. Such secondary infections have been called "superinfections." They have usually been observed 7 to 12 days after the start of penicillin therapy, and have been generally produced by gram-negative bacilli such as B. proteus, E. coli, or A. aerogenes.

The importance of frequent and careful bacteriological examinations is stressed in patients who show evidence of exacerbation of the clinical signs of infection a week or more after the onset of antibiotic therapy.

9. Supportive Therapy

Adequate supportive therapy is as important as ever in patients with acute trauma. Although obvious derangements in local and general physiology are frequently overlooked by clinicians in present-day chemotherapy, it must be remembered that the full therapeutic effect of the antibacterial agent will not be obtained if they are not corrected.

B. Prophylactic Chemotherapy in Acute Trauma

Prophylactic antibiotic therapy should be started promptly in all patients with major open soft tissue wounds or open fractures, and continued for at least five days unless special contraindications are present. The selection of the agent depends upon the location and nature of the wound and the probable contaminating bacteria. Under disaster conditions, in which there are many wounded patients, the choice of the antibacterial agent may be influenced by the supplies or personnel available. The oral route of administration and the use of prolonged intervals between doses, when possible, are useful in minimizing professional personnel and equipment in disasters. However, in normal periods, this is not necessary and may not be advisable.

Initial prophylactic chemotherapy may consist of:

1. Chloromycetin, terramycin, or aureomycin, 500 mg., every 4 to 6 hours orally, for the moderately injured who are able to take medication by mouth.
2. The parenteral administration of penicillin is recommended for those unable to take oral medication, and for all with serious injuries who are not sensitive.
   a. Crystalline penicillin G, 50,000 to 100,000 units, every 4 hours intramuscularly.
   b. Procaine penicillin G, 300,000 units, fortified with crystalline penicillin G, 100,000 units, preferably in aqueous suspension, may be given intramuscularly every 8 to 12 hours for 72 hours, then every 24 hours.
3. Under disaster conditions, chloromycetin, terramycin, or aureomycin may be given orally in doses of 750 mg., every 12 hours, or procaine penicillin G and crystalline penicillin G in oil, intramuscularly, every 24 hours.
4. In patients with wounds exhibiting extensive tissue necrosis such as severe lacerations, crushing injuries of muscle, compound fractures, and major arterial lacerations, aqueous penicillin G, 200,000 units, intramuscularly every 4

hours, or 500,000 units, every 8 hours.

5. In patients with wounds contaminated by fecal bacteria such as penetrating wounds of the abdomen, lacerations of the perineum or buttocks, or wounds of the retroperitoneal tissues, the following therapy is recommended.
   a. Aqueous crystalline penicillin G, 100,000 to 200,000 units, every 2 hours intramuscularly, and streptomycin, 0.5 gm. intramuscularly every 8 hours. Streptomycin is usually discontinued in 4 to 7 days. Penicillin without streptomycin is the choice of some physicians.
   b. Alternate choice is crystalline penicillin G, 500,000 units, and streptomycin, 0.5 gm. intramuscularly, every 8 hours.
   c. Second alternate is chloromycetin, aureomycin, or terramycin, 500 mg., intravenously every 12 hours, given slowly in 5 per cent glucose solution.

At the end of five days antibiotic therapy is discontinued if there is no obvious infection, continued until infection has been controlled, or modified as indicated.

C. Therapeusis of Established Infection in Acute Trauma

1. For patients with slight or only moderate local infection, in whom no serious infection is anticipated, the same antibiotics and dosage schedules are recommended as for prophylactic use (B-1,2,3,4).
2. In wounds with invasive established infections, the choice of antibiotic depends upon the infecting bacteria.
   a. In hemolytic streptococcal or staphylococcal infections of moderate severity, the choice of antibiotic treatment may be made from the following:
      (1) Crystalline penicillin G, 50,000 to 100,000 units, every 3 or 4 hours intramuscularly.
      (2) Crystalline penicillin G, 500,000 units, intramuscularly, every 12 hours.
      (3) Procaine penicillin G, 300,000 units, and crystalline penicillin G, 100,000 units, intramuscularly every 12 to 24 hours.
      (4) Chloromycetin, terramycin, or aureomycin, 500 mg., every 4 to 6 hours orally, or 750 mg. every 8 hours.
   b. In fulminating streptococcal or staphylococcal infections or septicemia:
      (1) Crystalline penicillin G, 100,000 to 200,000 units, every 2 hours intramuscularly or intravenously, or
      (2) Crystalline penicillin G, 500,000 units, intramuscularly every 8 hours.
      (3) If bacteria are resistant to penicillin, change to antibiotic which is effective, such as chloromycetin, aureomycin, or terramycin (as in 2.a.(4)).
   c. In severe infections caused by fecal bacteria, such as peritonitis, retroperitoneal phlegmon, crepitant cellulitis, putrid empyena and mixed infections of buttocks, thighs, or perineum, essentially the same antibiotic dosage schedules may be used as in B.5. a, b, c.
   d. In established clostridial myositis or true gas gangrene, the choice of effective antibiotics is:
      (1) Aureomycin, terramycin or chloromycetin in doses of 500 mg. intravenously every 8 to 12 hours, or
      (2) Crystalline penicillin G, 1,000,000 units, intramuscularly every 3 hours.
   e. Serious pseudomonas (pyocaneus) infections may be treated with the following antibiotics.
      (1) Polymyxin B, 2.5 mg. per kilo of body weight per day, given in three or four divided doses every 8 or 6 hours for 5 to 7 days under close supervision. One per cent procaine as a diluent minimizes pain at site of injection. A daily dose of 200 mg. should not be exceeded. Patients treated with polymyxin should be observed closely for signs of renal or neurological toxicity.
      (2) Chloromycetin or terramycin is less effective but may be used successfully in about one fourth of the cases.

III Antisera

The only antisera of clinical importance which are used currently for the prevention or control of infections in patients with wounds are tetanus antitoxin and pentavalent gas gangrene antitoxin. Antivenin, containing antitoxins for the toxins of rattlesnakes, copperhead, and cottonmouth moccasin snakes, may be used in the treatment of bites by these snakes, but their use does not come within the scope of this article.

A. Tetanus

1. Prophylaxis

Tetanus can be prevented by the use of antitoxin much more effectively than it can be treated after the disease is established. Therefore, every effort should be made to prevent this dreaded complication of wounds. In fact, the authors favor general immunization of all civilians against tetanus by three injections of 0.5 to 1.0 cc. of tetanus toxoid in an effort to stamp out this disease.

a. Tetanus antitoxin, 1,500 to 3,000 units hypodermically, after a negative skin test, should be given as soon after injury as possible to those who have not been previously immunized with tetanus toxoid. A dose of 1,500 units may be used for minor injuries, but a dose of 3,000 units is recommended for more extensive soft tissue wounds, open fractures, and injuries caused by blank cartridges and firecrackers. A dose of 3,000 units is suggested when prophylaxis has been delayed for 24 to 48 hours, and a larger dose of 10,000 units when the delay is more than 48 hours. The injections are made subcutaneously immediately after injury, but intramuscularly when delayed for 24 or more hours.

b. If hypersensitivity exists, desensitization should be accomplished by giving increasing fractional amounts starting with 0.001 to 0.01 cc. and at intervals of 20 minutes. Adrenalin should be available in the event of anaphylactic reaction.

c. If the wound is extensive or grossly infected, a second dose of 1,500 to 3,000 units of antitoxin should be given in 5 to 7 days.

d. Tetanus toxoid, 0.5 to 1 cc. (according to the instructions on the package) may be given hypodermically instead of tetanus antitoxin to those who have previously received a series of 3 tetanus toxoid injections.

2. Therapeusis

Every effort must be made to establish the diagnosis of tetanus at the earliest possible time. When the diagnosis has been made or cannot be ruled out, the following treatment with antisera is suggested.

a. Preliminary skin testing of the patient to determine the presence or absence of sensitivity to horse serum.

b. If the skin test is negative, an intial intravenous dose of 50,000 units of tetanus antitoxin is given.

c. If the skin test is positive, rapid desensitization is carried out to permit the injection of a therapeutic dose.

d. An intramuscular injection of 40,000 units of tetanus antitoxin may also be given.

e. 10,000 to 20,000 units of antitoxin may be injected intrathecally by lumbar puncture.

f. Infiltration of tissues around site of injury by multiple injections of 10,000 units of antitoxin.

g. If considered advisable, local excision of the wound may be done one hour after the local injection of antisera.

h. Daily injections of 5,000 units of antitoxin until the disease is obviously under control.

i. The use of curare-like drugs does not come under the scope of this chapter.

B. Gas Gangrene

1. Prophylaxis

Early and adequate surgery is still the most effective means of preventing gas gangrene since it eliminates the conditions necessary for the propagation of bacteria and removes most of the contaminating bacteria. Adequate surgery implies early meticulous incision of all dead and devitalized tissue, removal of dirt, clothing, and other foreign material from the wound, preservation of the blood supply, relief of tension, and sufficient drainage when indicated. There is considerable evidence that the prophylactic administration of gas gangrene antitoxin is of little practical value in the prevention of clinical gas gangrene. The authors have not administered it prophylactically in acute injuries in the past nine years. Many surgeons, however, use the combined tetanus and gas gangrene antitoxin containing 1,500 units of tetanus, 2,000 units of Cl. welchii, and 2,000 units of vibrion septique antitoxins. If given, it should be injected subcutaneously as soon after injury as possible. When treatment has been delayed for 24 hours or more, its injection should be intramuscular. When available, trivalent or pentavalent gas gangrene antitoxin should be used instead of the bivalent.

2. Therapy of Established Gas Gangrene

There is considerable confusion regarding the value of serotherapy in the treatment of established gas gangrene. However, the evidence suggests that the use of

antitoxin, in conjunction with adequate surgery, aids in the control of associated toxemia. This is of particular value in the first 36 to 48 hours after the start of antibiotic therapy until the full effect of the latter is possible. Until more conclusive evidence is produced to contraindicate its use, the following recommendations are made:

a. The earlier the antitoxin is started, the greater will be its effect. Early diagnosis is of the greatest importance, permitting prompt surgical treatment, use of antibiotics, and administration of antitoxin.

b. Pentavalent preparations should be used, if available, containing 10,000 units of Cl. welchii, 10,000 units of vibrion septique, 1,500 units of Cl, oedematiens, 1,500 units of Cl. sordellii, and 3,000 units of Cl. histolyticum antitoxins per vial.

c. Before injecting the antitoxin, preliminary skin testing of the patient for sensitivity to horse serum is done.

d. If negative, an initial dose of 2 to 4 vials of pentavalent gas gangrene antitoxin is given intravenously promptly. The dosage or number of vials used is decided upon after a consideration of the duration, extent, and the rapid course of the infection, as well as the apparent degree of intoxication.

e. If the toxemia is not significantly altered within 4 to 6 hours, the initial dose of antitoxin may be repeated.

f. Thereafter, a daily injection of one (1) vial of pentavalent gas gangrene antitoxin may be given until the infection has been brought under control.

The Child's Eyes

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The Important Years

At birth the visual acuity of a normal infant is little more than light perception. The use of the eyes, the development of discriminative vision, and the coordination of binocular movements are processes which are learned as the plastic neural system of the first few years of life is being perfected by growth and training. The foveas are formed by the third month of extrauterine life, and by the fifth or sixth year the basic reflexes and capabilities which are to be present for the entire lifetime have been largely determined. It is obvious that the pre-school visual experience of a child is of major importance, and that waiting for school examinations to disclose eye defects is in the nature of "locking the stable after the horse is stolen."

Amblyopia

The development of sight is, of course, mostly automatic or involuntary, and usually proceeds to satisfactory binocular vision in the course of time. When one or both eyes fail, for one reason or another, to attain normal vision, the subnormal acuity is termed "amblyopia"[1]. Any condition which prevents the normal use of an eye for an extended period of time during the first few years of life will lead to amblyopia in that eye. If the restriction of use is unilateral, the unfettered eye may develop so far beyond the other eye that, even though all restraining influence may be subsequently removed, the retarded eye may never resume functional development. Such unilateral amblyopia may occur in the absence of even the slightest observable organic defect and may be present for many years without discovery by the individual who sustains it.

Etiology

Often the cause of failure to develop good vision is apparent in a congenital or an acquired defect (squint, birth injury, cataract, retrolental fibroplasia, traumatic opacity, choroiditis, retinal coloboma, etc.). In those cases without obvious defect, the ophthalmologist may often find the probable cause by proper investigation

Refractive errors are among the frequent causes of amblyopia, and, happily, such cases are most amenable to treatment if corrective measures are instituted soon enough. A typical example may be

Read before the Samuel Brown Journal Club, Lexington, Ky., November 24, 1953.

as follows: The patient is a two-year old child; he is unusually far-sighted (hypermetropic) and begins to use the eyes more for near vision as books, etc., receive increasing attention. When accommodation necessary for near vision is added to that of excessive far-sightedness, the strain on the relatively undeveloped muscles of accommodation becomes too great to be tolerated by some individuals. Since accommodation and convergence are synkinetic (acting together) functions, there is also a strain on the muscles of convergence. The fatigued or asthenopic child may do several things when this situation prevails; if the overworked muscles rebel and the eyes cease to focus together, diplopia ensues. Repeated often enough for a sufficient length of time, the intolerable condition of two images is resolved by the suppression of the image of one of the eyes. Or, another child may use either eye alternately, yet never attain the perfected reflexes of simultaneous binocular vision manifested in the ability to fuse and obtain stereopsis. Alas, this child can never fully appreciate the entertainment of the 3-D movie nor the more recent 3-D comic books. More seriously, in later life he cannot participate in certain activities (e. g., Air Force pilot, etc.); and he is saddled with a defect which cuts down his factor of safety when only one eye is normal. One of the most frequent causes of amblyopia is marked anisometropia, a condition in which the refraction of one eye differs considerably from that of the other eye. When one eye is essentially emmetropic (has normal refraction) and the other is markedly myopic (near-sighted) or markedly hypermetropic (farsighted), the child usually uses the "good" eye and ignores the "poor" eye which would have to work so hard to obtain a clear image. This also holds true in cases of high astigmatism—the eye giving the better image is used and the other is ignored; or, if there is no difference in the quality of images, the high astigmatism may lead to amblyopia in both eyes.

An eye which is highly amblyopic, or which suppresses when the other is used, often deviates from coordinated movement with the other eye because the stimulus of fixation is inoperative. It must be remembered that coordination here is a learned process which depends upon the satisfaction obtained by imposition of two images, one upon the other, to give a fused image more clear than the uniocular image. In other words, amblyopia may cause squint (strabismus). Conversely, a primary strabismus may cause amblyopia.

Consequence

Regardless of the cause of amblyopia, observable or hidden, the significant factor to be emphasized is that when amblyopia occurs and remains uncorrected through the fifth or sixth year, recovery does not subsequently take place essentially beyond the stage of development of the vision which obtained at the inception of the amblyopia. Consequently, the success in treating either amblyopia or strabismus will depend not only on the etiology of these conditions but very significantly on when the etiologic factor became active. If amblyopia occurs after satisfactory development through the sixth year, there is always a better chance to return to normal vision.

When visual perfecting processes are interrupted before normal acuity and normal reflexes are developed, the amblyopia is called amblyopia of arrest. When, however, the eyes have once acquired normal acuity and coordinating reflexes, they may become impaired by non-use over a sufficient period of time and we then have what is called amblyopia of extinction. Either type of amblyopia may be termed amblyopia ex anopsia, or dimness of vision from non-use.

Rationale of Treatment

The foregoing discussion indicates that, in broad principles, the rationale of treatment is to encourage by any means possible the active use of the amblyopic eye, for full development of binocular vision is contingent on the use of both eyes during the early learning period of visual activity.

Regardless of the quality and duration of any treatment which may be given, some cases of amblyopia never show a satisfactory improvement in visual acuity. Other cases show improvement if treatment is sustained or repeated at intervals[2]. Patience and persistence coupled with cooperation among parents, the family physician, the child and the ophthalmologist are essential. Each one should realize that the breaking of ingrained habits and the establishment of correct reflexes may take a long time. Success sometimes will depend on how well the parents and the family physician understand what is being attempted. Thus "patching" the nor-

mal eye is one of our most effective means of forcing the use of the other eye. Unless done correctly, however, the procedure is worse than useless. The normal eye should be completely covered by a light-occluding pad, and this should be worn constantly, every day, all day, and removed only for cleansing the eye and possibly while sleeping. Here is where faltering in treatment and patience is most likely to occur. If immediate results are not forthcoming, parents and patients often tire of the procedure which is so abnormal. The family physician should be able to assure the parents that patching the good eye will not harm it in any way, and when he is asked if "the patch can be left off while Johnny goes to a party," the answer should be "No!" Furthermore, an occluder clipped over the eye-glass on the side to be covered is not a satisfactory substitute for patching.

Surgery

Extraocular muscle surgery is an important means of treating amblyopia when strabismus is present. Yet this is not a substitute which obviates all necessity for tedious measures such as orthoptic training, patching, etc. Indeed it is tempting to take the easier and more dramatic course and resort to surgery, but the ultimate result often is failure when due consideration is not taken to insure development of reflexes which tend to keep the eye straight. The goal, in pre-school children especially, should be more than cosmetic straightening of the eyes. The latter may be all that is possible in the older child.

For Better Vision

What should, then, be done for the betterment of children's eyesight? The obstetrician can advise parents on likely appearance of myopia, high astigmatism or certain congenital conditions which may appear if these characteristics are pronounced in the parents. At birth he gives the required attention to the eyes, and, if the child is premature, he is on the lookout for retrolental fibroplasia. The parents, the family physician and the pediatrician recognize that any appearance of squint or of nystagmus which is more than fleeting calls for investigation. Unfortunately there are still physicians who will tell parents that the child "will grow out of" his squint. The child's visual acuity should be observed as part of a general regular physical examination, and if suspicion of defect is found, referral for evaluation is indicated. Every child between two and four years of age should ideally be examined by an ophthalmologist. Unhappily there are not enough ophthalmologists even to approach this ideal. However, if the supreme importance of the first few pre-school years is kept in mind, there will be increasing resort to examination and treatment at this period, and there will be fewer amblyopic individuals unnecessarily handicapped for life.

REFERENCES

1. In broad terminology; the term is often limited to subnormal vision occurring where no observable cause is present.

2. Ryerson, F. S. & Cahalan-Kresge Eye Institute Bulletin, August 1952, p. 3.

Where and how the physically handicapped person can be fitted for the business world is the theme of a new film which has been added to the library of the AMA's Committee on Medical Motion Pictures. "America's Untapped Asset" is a 13-minute film the basic purposes of which are to encourage employers to hire the physically handicapped and to illustrate some of the many types of work in which the handicapped person can compete just as effectively as the normal person.

The addition of hormones to facial creams does not result in any greater improvement in the appearance of the skin than would the continued use of an ordinary emollient cream, is was concluded by a member of the AMA's Committee on Cosmetics after a three months study on the subject. No appreciable difference was visually observed in the different sides of the faces of 27 women who were asked to apply a hormone cream to one side of their face and an ordinary facial cream to the other side each night before retiring.

For its promotion of Conferences on Physicians and Schools which are resulting in more adequate school health services, the AMA's Bureau of Health Education received the 1954 Program Citation of the American Academy of Physical Education, the honor society of physical educators. W. W. Bauer, M.D., director of the bureau and originator of the conferences, recently accepted the citation at the academy's annual banquet at the Statler hotel, New York.

Button Hole Incision in Perforated Duodenal Ulcer

HOWARD E. DORTON, M.D., M.S.
(SURG.) FACS*
Lexington

Perforated duodenal ulcer has a morbidity and mortality rate proportional to the time lapse from perforation to closure. The reported mortality rates vary from 2% for those patients treated within seven hours, (1) to 20-30% for those in whom closure is delayed for as long as 24 hours. (2)

Wound complications contribute to the morbidity and mortality rates We have found during the past few years in our practice that the smaller the incision required for adequate treatment, the lower the incidence of complications of all types, wound and otherwise.

It is interesting to note that in most cases, a button-hole incision directly over the duodenal region is sufficient to accomplish the usual objectives of surgical treatment, namely, closure of the perforation and aspiration of the spilled gastroduodenal contents. Furthermore, the operative procedure is shortened to just a few minutes which is much easier on the patient in many ways. Anesthesia is less of a problem, early ambulation is easier and splinting of the chest is lessened, thereby reducing peripheral vascular and pulmonary complications; wound infections are less and, of course, wound separation cannot occur as readily. Robertson and Akers (3) recently reported 12 dehiscences occurring in a group of 92 cases in which the standard large incision was apparently used.



Fig. 1. "Button-hole" incision for exposure, and technique of closure of the usual perforated duodenal ulcer.

Technique

After the diagnosis has been made and the patient gotten into proper condition to stand surgery he is given a spinal anesthetic. The probable location of the duodenum is determined from the usual anatomic landmarks and from examination of the abdominal scout films used as an aid in making the diagnosis of ruptured viscus. A longitudinal incision (Fig. 1) about two inches long is made over this area. The anterior rectus fascia is opened along the same line and the rectus muscle is split, exposing the posterior rectus sheath. Thyroid retractors, (Green, McBurney, Lahey) are excellent for obtaining exposure. The suction is readied and the posterior sheath and peritoneum are opened longitudinally. The suction tip is gently introduced and the spillage drawn off. The opening in the completely relaxed abdomen is then lifted about by the retractors until the pyloric region is identified. The perforation of the anterior duodenum usually can be seen without difficulty. An intestinal suture on a small, curved needle is then introduced into the peritoneal cavity on a long slender needle holder. The point of the needle then picks up the duodenal wall on one side of the perforation and the suture is used to elevate the duodenum so that a second bite of the needle can be taken across the perforation. This is tied and held as a guide suture. Other sutures are placed as needed. An omental tag is then drawn over the duodenal closure and fixed with one or two sutures.

The wound is closed in any way suitable to the operator. We use catgut to close the peritoneum and posterior fascia. The wound is flushed thoroughly with normal saline. The anterior fascia is closed with horizontal mattress sutures of medium black silk. The skin is closed with interrupted silk sutures. Three are usually sufficient. A small sliver of soft rubber tissue occasionally is used as a subcutaneous drain for 48 hours in those

*From the Surgical Group of Dorton, Webb, Royalty and Moore.

(Continued on page 462)

Case Discussions *

FROM THE LOUISVILLE GENERAL HOSPITAL

A Case of Diverticulitis

Presentation of the Case:

Dr. James C. Drye,
Department of Surgery

Diverticulitis is assuming growing importance as our population is increasingly becoming older. Its complications, colonic obstruction and perforation can kill as readily as when these are produced by cancer of the colon. It presents the additional hazards of fatal hemorrhage and abscess formation.

Presented, is an example of complete colon obstruction occurring during the first attack of diverticulitis of the sigmoid colon.

R. S., Case No. 194944, Louisville General Hospital

This 63-year-old male was admitted with chief complaints of abdominal cramping and alternating constipation and diarrhea. Four weeks before admission he developed cramping and mid-and lower abdominal pain associated with frequent small, brown, semi-solid, and liquid stools which produced transient pain relief. He felt constipated and began to take cathartics. These symptoms persisted until admission. He passed no blood. His abdomen was distended and he noticed loud gurgling. Only on one occasion did he vomit normal gastric content. His appetite was fair, but he did not eat much as it made him feel full.

He was previously well and past history was non-contributory.

Physical Examination

Temperature 99, Pulse 80, Respiration 22, Blood Pressure 124/82. He was of average development and nutrition, and looked about his stated age. He was in moderate discomfort, but not in acute pain. The abdomen was convex, particularly in the lower portion. The percussion note was tympanitic. There was definite but slight tenderness over the left lower quadrant. At intervals of four to five minutes waves of rapid, peristaltic sounds could be heard

Rectal examination showed the rectum to be collapsed and empty. The sigmoidoscope could be introduced only 6 inches, where sharp angulation and redundancy of the mucosa prevented further passage. No pathology was seen.

Laboratory Examination

Findings were not significant.

X-ray films of the abdomen showed massive gaseous distention and large fluid levels in the colon from the cecum about to the beginning of the sigmoid colon. No gas was seen in the small intestine.

Diagnosis

Obstruction of the colon, closed loop, at the sigmoid due to either carcinoma or diverticulitis.

Operation

Two hours after admission a simple loop colostomy was performed for relief of distention. No exploration of the abdomen was done because of the hazard of peritonitis from trauma to such a paper-thin colon, and because any resection would be dangerous in the presence of such obstruction.

Further Course

The patient was immediately relieved of his symptoms and he was discharged on the fifteenth hospital day with a functioning colostomy. On the last hospital day x-ray studies of the colon distal to the colostomy showed an irregular area of narrowing in the middle third of the sigmoid and it was concluded that the previous obstruction probably was the result of an inflammatory process, most likely a diverticulitis.

Three months later he was readmitted for abdominal exploration. The apex of the sigmoid loop was firmly attached to the anterior surface of the sacrum so that the bowel was sharply angulated and the lumen constricted. No diverticula could be seen grossly. A conservative resection of the sigmoid was done. Examination in the pathological laboratory revealed an old, healing, inflammatory reaction in the appendices epiploicae and three diverticula.

The patient has made an uneventful and full recovery. The transverse colostomy has since been closed.

*Editor's Note:

This is the first in a series of presentations of a new permanent department, "Case Discussions," which is being established by the Journal of the KSMA. Joseph C. Bell, M.D., Louisville, is the Editor of this new feature.

Dr. Everett L. Pirkey, Department of Radiology

"Diverticulosis of the colon has a roentgen appearance consisting of multiple 0.5 to 1.0 rounded, smooth collections of barium outside the colonic lumen, best seen after evacuation. They indicate herniations of the mucosa through the muscularis of the colon. They are most frequent in the sigmoid, and their frequency decreases toward the cecum.

When inflammation occurs, the barium enema will show a constant narrowing and fixation in the inflamed area, which is usually tender. In recurrent or chronic diverticulitis, narrowing of the colonic lumen may be demonstrated by barium enema, and may even simulate carcinoma.

Hemorrhage has no characteristic roentgen findings, and it is impossible to show which of the diverticula is bleeding. However, if there is evidence of diverticulitis in one area, the bleeding is probably coming from that site. It must ever be kept in mind, however, that carcinoma may develop in an individual with a diverticulosis of the colon or in one who has had previous single or repeated attacks of diverticulitis. Differential diagnosis in such cases may be most difficult or at times impossible."



Figure 1. Admission upright film of the abdomen showing complete obstruction at the sigmoid colon. There is marked distention of the proximal two-thirds of the colon with multiple fluid levels. Little gas is seen in the small intestine.



Figure 2. Several loops of the barium-filled sigmoid colon are seen on film taken after subsidence of acute symptoms. Several small diverticula are apparent near the lower edge of the illustration, and the narrowing between the arrows indicates the area of previous inflammation which caused the obstruction shown on Figure 1.

Dr. Arthur M. Schoen, Department of Medicine

"The incidence of colonic diverticulosis in persons over 40 years of age is between 3 and 10 per cent. In 32 per cent of cases of colonic diverticulosis there are also diverticula of other parts of the gastrointestinal tract. Uncomplicated diverticulosis is an innocuous structural defect which requires no active treatment. However, a variable degree of diverticulitis eventually occurs in almost all of these cases, and about 5 per cent of these will have complications requiring operative treatment.

The management of uncomplicated diverticulitis in the acute stage is medical and consists of time-tested measures which

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SPECIAL ARTICLES

THE MEDICAL PROBLEM OF THE LOW INCOME GROUP*

WALTER B. MARTIN, M.D., Norfolk, Virginia

President-Elect, American Medical Association

We can be justly proud of the progress that has been made in extending the benefits of modern medical care to an increasingly large number of our total population. The quantity of medical care now available to the American people is greater than it has ever been in the history of this country. The quality has steadily improved and is continuing to improve. While the cost of medical care has increased very strikingly in the past 15 years this has been considerably less than the advance of the total living cost.

A large part of this increase in cost of medical care is a reflection of the much greater utilization of hospital care which has gone along with the extension and improvement of hospital facilities and the development of new methods, and techniques in medical practice. The greater cost of hospital operation has been brought about by improvement in their facilities, increase in personnel, and the sharp rise in labor and food costs. As far as the patient is concerned this has been compensated for to a considerable extent by a much shorter period of hospital stay and by a striking improvement in mortality experience.

Figures drawn from a report of the United States Department of Labor for the third quarter of 1952 reveal that living costs have increased 90.8% against the 1935-39 base line while medical costs have increased only 65.5% in the same period. In 1935-39 and 1950 the average weekly wage rose 165% while physician charges climbed only 48%. As a result of new medical procedures that shorten the length of illness and reduce hospital stay the cost of many illnesses is often actually less now than it was 15 years ago.

As a result of the rapid growth of plans for the pre-payment of hospital costs a major fraction of the insurable population in this country has some type of coverage against the cost of hospital care. At the present time our ninety-one million people in the United States carry pre-payment protection against the cost of hospitalized illness. The growth of this form of insurance has been so rapid since 1938 that if the present rate of growth continued the entire population would be covered by 1957. This is obviously not possible since there is a considerable group of individuals who are non-insurable. In addition to this approximately seventy-three million people are covered against surgical costs in hospitals and approximately thirty-five million against medical costs. We may well be justly proud of the progress that has been made in breaking down an economic barrier between the people and good medical care. We cannot, however, afford to be complacent. There still remains a very large number of people who are not insured and who cannot meet the cost of illness at the time it occurs.

This problem is somewhat simplified if we consider that only one out of eight of the population in any single year, have illnesses of sufficient severity to need hospital care. This 12% of our people that go into hospitals incur approximately 60% of the total medical bill. The remaining 88% are those with relatively minor illnesses not requiring hospital care and those not ill. These incur only 40% of the total medical bill of the nation. It is obvious that if a plan can be developed for financing the cost of hospitalized illness much of the problem will be solved.

Our most urgent problem at present is how to provide good medical and hospital care for the low income group. This is important not only from the standpoint of making good care available for a group of individuals that are not now protected and who are unable to pay for the cost of their care when illness occurs but is also important from the standpoint of meeting the financial needs of the hospitals. If sound hospital care standards are to be developed and maintained throughout the entire country hospitals must be properly financed. Operating costs have risen sharply. The relative value of the endowment dollar has fallen just as precipitantly. If we are to meet the financial needs of the hospitals and render the service that it needs for the total population as well as the low income group, methods must be devised for reimbursing the hospitals for services rendered these patients.

*An address given before the Annual Dinner Meeting of the Jefferson County Medical Society, January 18, 1954, Kentucky Hotel, Louisville.

It might be well at this time to break down the low income and non-pay group into several categories and to consider each of these groups separately.

The age group over 65 now constitutes an important and growing segment of our population. At the present time 8% or over twelve million of our population are in the age group of 65 or over and this group is still rapidly expanding. This is a particularly important section of the population since in it illness occurs more frequently and is likely to be more prolonged. The over-all picture here, however, is not too discouraging. Over four million of these people are employed and over four and one half million have some form of social insurance either private or governmental. On the other hand over two and one half million are on the old age assistance roll. We can assume that a considerable number of the total group have accumulated savings or could reasonably expect assistance from relatives. They present, however, a serious problem because of their high rate of hospitalization and high incidence of chronic or prolonged diseases. The average cost of their health care is greater than the average for the total population.

There is always a residual unemployed group present even in times of high employment. In September, 1953, only 9/10 of 1% of our population was unemployed. Including their dependents this would amount to about 2% or a total of around three million individuals. This number is less impressive, however, when you consider that 60% of them were unemployed for four weeks or less and that only 14% were unemployed for more than three months. In 1952, 57% were covered by employment insurance. The situation as to unemployment, however, may change and is changing. With a rising rate of unemployment the problem of hospital service of the unemployed group will become a much more significant one.

The temporarily disabled constitute a significant part of our population in the neighborhood of four and one half million people. Sixty per cent of these are disabled for a period of longer than a month. They constitute a very important problem especially from the standpoint of rehabilitation. These are the temporarily disabled. Proper measures and facilities to hasten their rehabilitation would represent a real economic gain for the country in addition to aiding the financial situation for the individual and his family. The needs of this group are partly met through workman's compensation.

The public assistance group of over five and one half million, includes certain of the aged, the dependent children, the blind, the totally disabled and the general assistance cases. The aged now constitute about 47% of this division. They are increasingly being covered through old age and survivors insurance and this coverage is continuing to increase. They present a definite problem since their medical needs are not fully met from federal or state assistance that they now receive.

Over and beyond the specific groups that have been mentioned there are large numbers of individuals in the low income bracket outside of these categories. These are the indigent, and the so-called medically indigent. This is a large fluid and undefinable group quite different from the divisions previously noted. Whether people fall in the medically indigent group depends on their income, the size of the family, on the nature and duration of their illness and often the area in which they live. People are constantly moving in and out of this group, depending upon many foreseeable and unforeseeable circumstances. There are no acceptable standards that can be applied throughout the country as a whole that would satisfactorily define this group. They constitute a large and important fraction both from the standpoint of the imposed burden on hospital finances and because of the problem of providing them with the proper quantity and quality of medical care. Just how large this group is actually is almost impossible to estimate. Many of them are among the aged and their number is augmented by unemployment, disability, and by various hazards of life. While we speak of the medically indigent and the outright indigent it is often impossible at any one time to draw a line of demarcation between them.

The medically indigent in general are those individuals who have sufficient incomes to purchase the necessities of life and a surplus that could be used to provide pre-payment insurance against the hazards of illness. They are not, however, without such protection, unable to meet the cost of the illness at the time it occurs. The size of this group is being diminished and can be further diminished almost to a vanishing point by further extension of pre-payment protections. This can be accomplished by educating the population in the importance of giving high priority to pre-payment protection and by developing better methods and techniques of salesmanship by the agencies selling such coverage. It is notable that the large industrial states, with small rural population, have the highest percentage of coverage while the less industrialized and the rural states have the lowest. It is particularly important to develop methods of bringing pre-payment protection within the reach of our rural population.

This situation from the standpoint of the

hospitals is obviously difficult and in many instances is bound to be reflected in either deficiencies in facilities, and a poorer quality of service, or in financial deficits. How large are these deficits? By making certain assumptions as to incidence and duration of illness, types of facilities required, quantity of service rendered, there remains an unpaid balance for hospital care of one hundred and twenty to one hundred and fifty million dollars, per annum. Part of this deficit is covered by private endowments, special gifts, services rendered by auxiliary organizations, and payments to hospitals by special private health agencies. These contributions do not cancel the deficit. There remains hospital cash deficits or a lowered quality of service. This is not as great as it has been alleged in certain political circles. It is appreciable, however, and should be absorbed as rapidly as possible.

I believe that there are few individuals who are denied service, although this service is not always of the highest order. Traditionally the hospitals are charitable institutions, and this tradition is still preserved by most of them. They still extend their sheltering arms to those that cannot pay, or can pay only in part. The community welfare, however, requires that hospitals should receive payment from some source, or the quality of service rendered all members of the community may fall below a proper standard.

The most promising method of meeting the needs of the patient and the hospital is a further extension of voluntary pre-payment, both quantitatively and qualitatively, thus including a greater number of the medically indigent. This extension should not be numerical only, but constant effort should be directed to providing better coverage and longer periods of protection. While the prevention of abuses and misuses makes it desirable to preserve a contributory element on the part of the patient, the unpredictable factor in hospital costs should be fully covered. The "brake" should be applied in predictable areas, such as a fraction of the room rate, or a daily fixed charge. The complete, or so-called comprehensive coverage is adherently dangerous, since it encourages the abuse and misuse of available services. Such abuse eventually results in forcing up the premium rate. It further tends to depress the individual's sense of responsibility for his own health and that of his family.

The indigent group is made up of individuals whose income is so low, or whose understanding of the importance of providing for their future health needs is so deficient that they cannot, or they will not, purchase pre-payment coverage. These individuals, and their dependents, need and should have good medical care, but it should be financed at the time illness occurs. The responsibility for medical care of these individuals is primarily the responsibility of their community, and when necessary, of the state. Only at the local level can the facts of their medical and financial needs be properly determined. Joint action by the state and community, with community determination of the needs, has worked out successfully in many areas. Widespread deficiencies still exist in other areas both from the standpoint of the adequacy of payments to hospitals for services rendered, and in undue restrictions in accepting individuals in need of service.

If these principles involved here are accepted and deficiencies are recognized, communities will become more aware of the importance of reimbursement of hospitals for the cost of services rendered and of providing care for those who cannot pay. This is not only an act of charity, but to a high degree it is a form of self-protection. Sooner or later all members of the community will find their medical welfare affected by the quality of medical care available to them in their community.

Many proposals have been made and others will be made for the participation of the federal government in financing medical care of the low income group. There are many sound reasons why this should not be done. The fact of need can best be determined on the local basis. A dollar contributed on the local basis will buy a dollar's worth of service, whereas a dollar contributed in taxes to the federal government will suffer very considerable shrinkage as it filters back to the community or state in the form of a subsidy. Expenditure of funds raised locally are watched more carefully and are better safeguarded against abuses. The most compelling reason, however, lies in the field of power and the inability of the federal government to develop standards that can be properly applied to all parts of the country. If the federal government entered the program of providing care for the lower income group on a direct payment or insurance basis, it would be necessary to define this group and to establish some yardstick or standard by which to determine who would be eligible for payment of the cost of their care from public funds. Such standards could not have such a degree of flexibility as to be evenly applied in all parts of the country. Once standards were developed and applied, the political factors would come into play. Pressure would develop to extend or raise these standards so as to include more and more individuals under the program. One has only to note the creeping nature of veterans' benefits during the past thirty years, to have a preview of what would

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Coleman Johnston, 211 W. Second Street, Lexington (Alternate)	1955

COUNCILORS

		Term Expires
First District	J. Vernon Pace, 109-10 Citizens Bank Bldg., Paducah,	1956
Second District	Walter L. O'Nan, 237 Second St., Henderson	1955
Third District	Delmas M. Clardy, Hopkinsville	1956
Fourth District	W. Keith Crume, Bardstown	1956
Fifth District	Richard R. Slucher, Buechel	1954
Sixth District	L. O. Toomey, Bowling Green	1954
Seventh District	Branham B. Baughman, Frankfort	1955
Eighth District	Edward B. Mersch, 92 Arcadia, Covington	1954
Ninth District	J. M. Stevenson, Brooksville	1955
Tenth District	J. Farra Van Meter, 183 N. Upper St., Lexington	1955
Eleventh District	Hugh Mahaffey, Richmond	1954
Twelfth District	Garnett J. Sweeney, Liberty	1956
Thirteenth District	Charles B. Johnson, Russell	1955
Fourteenth District	John Archer, Prestonsburg	1956
Fifteenth District	Edward Wilson, Pineville	1954

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EDITORIALS

SPRING FASHIONS

In the medical profession one must be wise in judgment, diagnostically adroit and therapeutically fashionable. During the past few years atherosclerosis has been on the style ramp to receive the critical scrutiny of both research workers and clinicians. This attention is well deserved since the manifestations of atherosclerosis are encountered with increasing frequency in almost all age groups, and its disabling complications are seen with distressing regularity in the elderly patient. Despite concentration of thought and study, experimental and clinical, atherosclerosis is fraught with general confusion, a disorderly mixture of theories and aimless conflicts regarding control and treatment. The subject is plagued by argument, controversy and divergent hypotheses which is a real indication of the existing paucity of knowledge.

Most of the studies conducted have been concerned with cholesterol, cholesterol-phospholipid ratios, and serum lipoproteins in an effort to demonstrate the pathogenetic mechanisms in atherosclerosis. Persons with high serum cholesterol levels are known to develop atherosclerosis earlier and in a more severe form than do persons with normal or low cholesterol levels. In conditions such as diabetes mellitus, essential hyperlipemia, familial xanthomatosis, myxedema, and nephrosis, there is an associated hypercholesterolemia and atherosclerosis characterized by premature vascular degeneration. Controled studies have demonstrated higher cholesterol levels in patients with proved coronary atherosclerosis and in the experimental animal the production of atherosclerosis is regularly accompanied by hypercholesterolemia.

With such incriminating evidence, it was natural to indict cholesterol as the causative agent and since no other means were available to control serum cholesterol levels, it was logical that the low cholesterol diet emerge as a therapeutic style trend. Clinical investigation demonstrated a decrease in serum cholesterol levels in patients with established coronary atherosclerosis and with this decrease there was a statistically significant reduction in mortality from recurrent coronary thrombosis.

Many of the facts produced firm credence in the cholesterol theory of atherogenesis and the low cholesterol diet gained in popularity to become one of the vagaries of medical fashion. This tasteless and bulky diet was prescribed enthusiastically by sincere and conscientious physicians. To the patient, meals were an undesirable chore rather than pleasure and it was difficult to maintain such a diet for any length of time.

Later it was demonstrated that cholesterol could be synthesized by many cells and tissues of the body, and that endogenous synthesis was capable of maintaining cholesterol concentrations at normal levels even in the absence of cholesterol ingestion. There are also strong suspicions that low cholesterol diets can increase endogenous cholesterogenesis. The ultracentrifuge negative gravity flotation studies tend to indicate that the Sf 12-20 and Sf 20-100 lipoprotein fractions of serum, which afford a good index of the tendency to atherosclerosis, may be decreased significantly with weight reduction without restriction of dietary cholesterol. Post-mortem studies in a large series of cases indicate that the incidence of generalized atherosclerosis is directly proportional to the amount of adipose tissue deposited throughout the body. In each of the age groups studied the overweight individuals had the greatest amount of severe atherosclerosis and the underweight had the least.

It seems apparent therefore that cholesterol is not the sole causative agent in atherogenesis but that the total amount of fat is the most significant factor. Experimental and clinical studies recently have demonstrated an equal increase in cholesterol blood levels in persons maintained on high fat, low cholesterol diets and high fat, high cholesterol diets. Possibly some yet undiscovered fraction of serum lipid is responsible for atherosclerosis.

In the light of current concepts and present knowledge no dietary revolution is in-

(Continued on page 460)

President's Page

The month of June witnesses the graduation of many medical students and also the termination of hospital life for many interns and residents. To both of these groups of young physicians we owe many obligations.

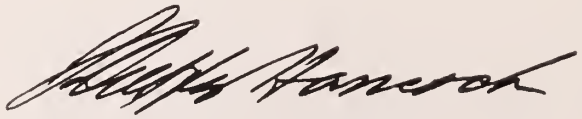
Foremost among these obligations is the extension of cordial fellowship to our new colleagues. In no way can this be done as well as by encouraging them to join their respective County and State Medical Societies and the American Medical Association. While special societies are desirable in many ways, the forementioned are the basic societies that make a physician part of organized medicine with a voice in its policy making.

Even some of us who are well established, fail to realize at times the advantages of State and County membership. We have been the recipients of their blessings so long that we take them for granted.

In the County Society acquaintanceship with one's colleagues is quickly attained. The ethical standards of the members are rapidly learned. Contacts are made with proper consultants and general practitioners for referral of work. The newcomer soon feels that he belongs not only in the medical society, but also in the community at large. If a Woman's Auxiliary is in existence, his wife's social life will be much more pleasant.

The State Society widens his horizons in every way. Most policies are determined at that level. The educational advantages are made available and properly advertised to him. Membership will include a subscription to the Journal which he will find most informative.

Let us do all we can to encourage such membership. Explain the advantages to the possible applicant and after he becomes one of us, follow through with cordial support and encouragement. We need him and he needs us.



PRESIDENT

ORGANIZATION SECTION

Outstanding Essayists to Take Part in Annual Session

Three more nationally prominent guest essayists, who will participate in the Annual Scientific Assembly at the 1954 Annual Meeting of the KSMA, September 21, 22 and 23 at the Columbia Auditorium in Louisville, have been announced by J. Duffy Hancock, M. D., Louisville, chairman of the Committee on Scientific Assembly.

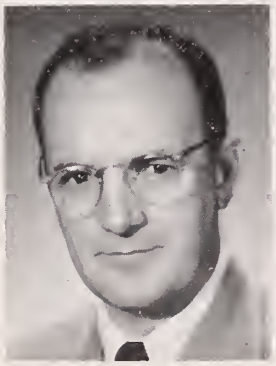


Dr. McCullagh

E. Perry McCullagh, M.D., Cleveland; John C. Peterson, M.D., Milwaukee, and Thomas J. F. O'Neill, M.D., Philadelphia, will address both the general scientific session and the host specialty group. There will be a total of eleven guest speakers.

"It should be remembered," Dr. Hancock pointed out, "that this year the Committee has planned an innovation, which is designed to give more KSMA members an opportunity to participate in the program, and which makes it possible for the specialty groups to have a half day scientific session of their own."

The 1954 pattern will develop as follows: there will be general scientific sessions all day Tuesday, September 21, Wednesday morning, September 22 and all day Thursday, September 23. But, on Wednesday afternoon, September 22, eight specialty groups have been invited to conduct scientific meetings simultaneously.



Dr. Peterson

Out-of-state speakers of the eight specialty groups will give papers before the general sessions as well as individual group meetings on Wednesday afternoon. While the eight specialty sessions are in progress, a KSMA member is free to select any of the eight meetings at any time he wishes.

Dr. McCullagh, guest of the Kentucky Chapter of the American College of Physicians, will discuss "Treatment of Hyperthyroidism" at the general session. His presentation before the specialty group will be "Differential Diagnosis of Pituitary Tumors." A graduate of the University of Manitoba, Canada, Faculty of Medicine, Dr. McCullagh has been head of the Section of Endocrinology and Metabolism at the Cleveland Clinic since 1934.



Dr. O'Neill*

"Immunizations in Infancy and Childhood," will be the subject discussed at a general session by Dr. Peterson, guest speaker invited by the Kentucky Chapter of the American Academy of Pediatrics. His topic at the group meeting will be "BGG Vaccination." Dr. Peterson is professor and director at Marquette University in the Department of Pediatrics which he assumed the responsibility of organizing in 1953.

When speaking to the general practitioners, Dr. O'Neill, prominent thoracic and cardiovascular surgeon, will present "Surgical Treatment of Stenotic Valvular Diseases." Before the Kentucky Chapter of the American College of Chest Physicians, he will discuss "Surgery of Heart Other Than Stenotic Valvular Diseases."

*Photographer: Fabian Bachrach, Philadelphia, Pennsylvania.

Dr. Bell Edits 'Case Discussions' New Journal Department

In order to further broaden the scope of appeal of the improved scientific section of the Journal of the KSMA, "Case Discussions," a new department edited by Joseph C. Bell, M.D., Louisville, is being carried for the first time in this, the June issue, according to Bruce Underwood, M.D., Louisville, editor.

A case discussion will be used in each forthcoming issue of the Journal on recommendation of the Advisory Committee to the Editor. One source of scientific material for the new department will be case discussions of universal interest obtained through Louisville General Hospital. Dr. Bell emphasized that case discussions prepared by KSMA members

(Contnued on page 450)



Distinguished guest speaker Walter B. Martin, M.D., Norfolk, Virginia, AMA president-elect, chats with a group of KSMA officers before his luncheon discussion at the Phoenix Hotel, scene of the Fourth Annual County Society Officers' Conference, April 15. From left to right are Dr. Martin, Bruce Underwood, M.D., Louisville, KSMA secretary and general manager; Mrs. Clyde C. Sparks, Ashland, president of the Woman's Auxiliary to the KSMA; J. Duffy Hancock, M.D., Louisville, president of the KSMA, and J. Farra Van Meter, M.D., Lexington, chairman of the Council.

House Votes Speaker May Issue Charter to Negro Society

The House of Delegates at its special meeting at the Phoenix Hotel in Lexington, April 15, voted to authorize the Speaker of the House to issue a charter to a state-wide component society made up of worthy Negro physicians if and when such application is made.

The motion which was presented to the House by J. Farra Van Meter, M.D., Lexington, chairman of the KSMA Council, is as follows:

"I move that pursuant to the provisions of Section 4 of Chapter XII of the By-laws of the association, the House of Delegates authorize the Speaker of the House of Delegates to issue, on behalf of the House of Delegates, a charter to a state-wide component society to be made up of worthy, qualified Negro physicians, if and when an application is made therefor, and provided that, in the opinion of the Speaker, said application is in compliance with the Constitution and By-laws of the association."

It was pointed out that the proposed state-wide component society would operate under the model KSMA County Medical Society By-laws and that its members would be entitled to representation in the House of Delegates on the same basis as other component county medical societies are.

Charles A. Vance, M.D., Lexington, presided over the special session as Speaker of the House. Included in those that discussed the motion were J. Duffy Hancock, M.D., Louisville, KSMA president, and Clyde C. Sparks, M.D., Ashland, KSMA president-elect.

Progress Noted in Standardization Of Insurance Claim Forms

Kentucky physicians incumbered with multitudes of insurance forms to fill out will be interested to know that considerable progress is being made by the health insurance industry in an effort to perfect for general use a set of uniform and simplified claim forms.

Since more than 100 million persons in the United States are now protected by health and accident insurance, numerous claim forms are being used to obtain needed information from physicians, hospitals and clinics.

The Health Insurance Council, composed of nine associations with which 600 insurance companies are affiliated, within recent years created a special Committee on Uniform Claim Forms to prepare reasonably brief, clearly worded forms that will still be adequate from the standpoint of sound insurance principles.

A group hospital insurance uniform claim form, prepared by the committee, is now in general use in many parts of the country. Five

attending physicians' statement forms used under regular life and group life insurance are now in final draft and will be used by 85 per cent of the companies participating in a study of the forms. Others being prepared are in preliminary draft form on which consultation will be made with medical groups and hospitals at both the national and local levels.

Proposed 1954-55 Budget Approved By Council, April 15

The proposed budget for the 1954-55 fiscal year was approved by the Council of the KSMA at its dinner meeting in Lexington, April 15, 1954. The budget had been drafted by the Budget Committee of the Council in a day-long session in the Headquarters Office, Louisville, March 18. The Executive Committee had approved the proposal in its meeting April 1, at a meeting in Louisville.

The budget was presented by L. O. Toomey, M.D., Bowling Green, councilor for the Sixth District and chairman of the committee. Other members of the committee are John Archer, M.D., Prestonsburg, councilor for the Fourteenth District, and Edward B. Mersch, M.D., Covington, councilor for the Eighth District.

Dr. Toomey told the Council that all commitments in the 1953 budget would be met and that a small surplus could be added to the association's reserve. He said it was anticipated that a small additional surplus could be added to the reserve at the end of the 1954-55 fiscal year. The Council voted its appreciation to the Budget Committee for its efforts.

Council Holds Special Hearing On Medical Education

Views on how best to increase facilities for the graduation of more physicians in Kentucky were given at a special hearing before the Council of the association, Thursday, April 15, 1954, at the Phoenix Hotel, Lexington.

The hearing which was held immediately after the County Society Officers' Conference and Special Meeting of the House of Delegates was arranged by the Executive Committee for the purpose of giving all parties interested in the subject an opportunity to express their views.

The Executive Committee invited among others the following groups to be heard: (1) group favoring a medical school in Lexington, (2) group favoring enlarging the University of Louisville School of Medicine, (3) group favoring a medical school in northern Kentucky, (4) group favoring teaching centers in smaller hospitals.

Following the hearing at which a number of KSMA members discussed the matter, the Council, in regular session, reviewed discussion. After careful consideration of the matter, Edward B. Mersch, M.D., Covington, moved that the Council go on record as commending the study of medical education in Kentucky and advocating that it be continued. The motion was carried.



One of the most popular features of the County Society Officers' Conference was the panel, "How My County Society Does It." Seated, left to right, the participants were: Charles Rutledge, M.D., Pikeville; Robert J. Hoffman, M.D., South Fort Mitchell; Walter R. Johnson, M.D., Paducah; Charles M. Francis, M.D., Bowling Green, and Richard G. Elliott, M.D., Lexington. Moderating the panel is Jean Clos, Louisville, executive secretary of the Jefferson County Medical Society.



Photos "Shot" at County Officers' Session, April 15, 1954

On the page opposite ar photographs of KSMA members and guests who attended or participated in the program of the Fourth Annual County Society Officers' Conference, at the Phoenix Hotel, Lexington, April 15, 1954. An explanation for each picture on the preceding page is given below:

(Top) Clyde C. Sparks, M.D., (left), KSMA president-elect from Ashland, spins a favorite yarn to the delight of Daniel L. Bower, M.D., Barbourville, KSMA Veterans Committee chairman; Guest Speaker Louis M. Orr, M.D., Orlando, Florida, AMA chairman of the Committee on Government Medical Service, and Garnett Sweeney, M.D., Liberty, KSMA councilor and president of the Kentucky Academy of General Practice.

(Second from top) Insurance was the chief topic of conversation when Kentucky Physicians Mutual president, Thomas Meredith, M.D., Harrodsburg, (left), got together with Guest Speaker Percy Hopkins, M.D., Chicago, (who spoke on voluntary insurance), B. B. Baughman, M.D., Frankfort, director of Physicians Mutual and vice-chairman of the KSMA Council, and John T. Bate, M.D., Louisville, chairman, KSMA Insurance Committee.

(Center) Weakness of AMA chief Washington watchman is obviously women. Mrs. Clyde C. Sparks, Ashland, president of the Woman's Auxiliary to the KSMA, (left), and Mrs. Garnett Sweeney, auxiliary's Rural Health Committee chairman, question Guest Speaker Frank Wilson, M.D., relative to latest developments on Capitol Hill.

(Second from bottom) County presidential problems are discussed as host Fayette County president, Rankin Blount, M.D., Lexington, (left), seeks the answers from Guest Speaker Arthur J. Roser, M.D., Fort Wayne, Indiana, president of the Allen County Medical Society, and David Cox, M.D., Louisville, president of the Jefferson County Medical Society.

(Bottom) Improvement of doctor-patient relationships occupies the attention of Glenn Bryant, M.D., Louisville, (left), KSMA Public Relations Committee chairman, W. Vinson Pierce, M.D., Covington, KSMA Education Campaign Committee chairman, as Guest Speaker and County P-R Chairman Richard Graves, M.D., Dayton, Ohio, make a point. Guest Speaker Arthur Tiernan, (dark suit), one of the top county P-R men from Evansville, Indiana, listens.

Council Acts on UMWA Advisory Committee Resolution

The Council of the Kentucky State Medical Association reaffirmed the principle of fee-for-service and free-choice-of-physician as it unanimously approved a resolution submitted by the KSMA Advisory Committee to the United Mine Workers of America Welfare and Retirement Fund, at a meeting in Lexington, April 15, 1954.

The resolution was presented by Carl Fortune, M.D., Lexington, chairman of the UMWA Advisory Committee, which he explained was drawn the night before at an emergency meeting of his committee. He pointed out that the special meeting was called because of the urgent requests of members of the Pike, Floyd and Johnson County Medical Societies.

After lengthy discussion and careful consideration, the following resolution was approved by his committee for consideration by the Council of the Kentucky State Medical Association:

"WHEREAS: The Kentucky State Medical Association by action of its House of Delegates at the 1952 and 1953 sessions, has approved the principle of free-choice-of-physician and fee-for-service payment of physicians: and,

"WHEREAS: It is believed that contract medicine, where fee-for-service practice is possible, is deterimental to the good medical care.

Therefore, be it resolved that the Kentucky State Medical Association acting through its Council support the physicians in the coal field area in their stand against being forced to accept salaried positions with the UMWA Welfare and Retirement Fund, and

Be it further resolved that the Advisory Committee KSMA to the UMWA Welfare and Retirement Fund be empowered to act as a negotiating agent in presenting to the UMWA Welfare and Retirement Fund any schedule of fees for service submitted by local medical societies, with the understanding that any schedule negotiated shall be referred back to the local medical societies involved for final approval."



AMA's President-Elect Walter B. Martin, M.D., Norfolk, Virginia, gave the luncheon address at the Officers' Conference in Lexington. KSMA President J. Duffy Hancock, M.D., Louisville, seated, presided.

Officers' Conference Draws 149 From 49 Counties

A record breaking attendance of 149 county society and state officers, committee chairmen, councilors and others representing a total of 49 Kentucky counties assembled in Lexington for the Fourth Annual County Society Officers' Conference, April 15, at the Phoenix Hotel.

Featured guest luncheon speaker was Walter B. Martin, M.D., Norfolk, Virginia, president-elect of the AMA, who discussed "How Can the County Medical Society Best Serve the Public?" One of the highlights of the afternoon session was a talk by Louis M. Orr, M.D., Orlando, Florida, chairman of the AMA Committee on Government Service, whose topic was "Government Medicine, VA Style."

Another feature of the conference was a panel discussion, entitled, "How My County Society Does It," moderated by Jean Clos, Louisville, executive secretary of the Jefferson County Medical Society. Five KSMA members participated in the panel discussion. Recordings which were made of all talks given at the conference are available for listening at the KSMA Headquarters Office.

According to a breakdown of attendance by counties, the 1954 conference leads the past three ones in number present and representation on a state-wide basis, indicating a growing interest in organized medicine on the county society level.

By counties, the attendance was as follows: Barren 1, Bath 2, Bell 2, Bourbon 2, Boyd 3, Bracken 2, Campbell 2, Casey 1, Christian 2, Cumberland 1, Daviess 1, Fayette 21, Floyd 1, Franklin 5, Garrard 1, Grant 3, Greenup 2, Hardin 2, Harlan 2, Harrison 1, Henderson 2, Henry 1, Hopkins 2, Jefferson 16.

Kenton 8, Knott 1, Knox 1, Laurel 2, Letcher 2, McCracken 5, Madison 4, Marshall 1, Mason 2, Menifee 1, Mercer 1, Montgomery 1, Muhlenburg 2, Nelson 2, Perry 1, Pike 2, Pulaski 1, Rowan 1, Russell 1, Shelby 1, Taylor 2, Todd 1, Trimble 1, Warren 5, Woodford 1, Others 22.

U. L. Students Attend SAMA in Chicago, May 1-3

Three students, Thomas L. Heavern, Fort Thomas, Raymond L. Rose, Lexington, and William P. Vonderhaar, Louisville, represented the University of Louisville School of Medicine's chapter of the Student American Medical Association at the Fourth SAMA Convention, May 1-3, at Chicago's Hotel Sherman.

Outstanding educational, business, and social features of the conference served as a drawing card for the 900 attending students who represented medical colleges throughout the United States. Chief scientific presentation, "On Becoming a Physician," was given by Leo H. Bartmeier, M.D., Detroit, Michigan.

At the committee meetings and sessions of the House of Delegates the SAMA representatives considered such issues as Veterans Administration's treatment of non-service connected disabilities, guaranteed minimum wage for interns and proposed legislation which would allow students to receive financial assistance from the government in return for services with the Armed Forces following graduation.

Other highlights of the well-rounded program included a forum on "The Future of Internships," a panel entitled, "First Aid for Ailing Chapters," and a discussion "Tell Me Dean," in which six deans evaluated the make-up and administration of schools of medicine.

DR. BELL EDITS

(Continued from page 445)

throughout the state would be considered for publication, provided they are written to meet the required standard qualifications.

Doctors Underwood and Bell expressed the joint hope that the case discussions will prove a valuable addition to the Journal and that members of the association would benefit by the new department.

Dr. Sweeney to Head Academy; Dr. Rolf Voted Award

John J. Rolf, M.D., veteran practitioner in Covington for 24 years, was the recipient of the second E. M. Howard award as the outstanding member of the Kentucky Academy of General Practice at the Third Scientific Assembly at the Netherland Plaza Hotel, Cincinnati, Ohio, April 21-22, 1954.

Burl Mack, M.D., Pee Wee Valley, was elected president-elect of the Academy. Installed as the new president was Garnett Sweeney, M.D., Liberty, along with William E. Becknell, M.D., Manchester, as vice-president and D. G. Miller, Jr., M.D., who was re-elected secretary-treasurer. Keith Smith, M.D., Corbin, is the retiring president. Daryl P. Harvey, M.D., Glasgow, was re-elected delegate.

A charter member of the AAGP, Dr. Rolf is a former president of the Campbell-Kenton County Medical Society and is remembered among KSMA members as a speaker at the Annual Meeting last September. He received his medical degree from the University of Cincinnati College of Medicine in 1929, interned at St. Elizabeth Hospital, Covington, where he has been a member of the hospital's active staff on internal medicine ever since.

The third annual session was well attended by approximately 250 general practitioners who heard various phases of medicine discussed by such outstanding speakers as C. O. McCormick, Sr., M.D., professor of Obstetrics and Gynecology at Indiana University, Indianapolis; James O. Ritchey, M.D., professor of Medicine, Indiana University; George Crile, M.D., and Irvin H. Page, M.D., of the Cleveland Clinic; George W. Kumpe, M.D., and Thomas W. McElhinney, M.D., of Covington.

Citation Awarded Dr. Howard

C. C. Howard, M.D., Glasgow, chairman of the Board of Trustees of the Kentucky Rural Medical Scholarship Fund, received an achievement citation for his outstanding work in medical rural service from Transylvania College at a Kentucky Day Dinner held in connection with the college's 175th anniversary celebration.



Distinguished physicians participating in the Kentucky Chapter Assembly of the American Academy of General Practice in Cincinnati, April 21-22, are, (back row, left to right) Keith P. Smith, M.D., Corbin, retiring president; George H. Lemon, M.D., Toledo, president of the Ohio Academy; Nathan J. Kursban, M.D., president of the Southwestern Ohio Academy; H. Burl Mack, M.D., Pee Wee Valley, president-elect, Kentucky Academy; (front row, left to right) Joseph Lindner, M.D., Cincinnati, member of the Board of Directors of the national academy; J. Duffy Hancock, M.D., KSMA president; and Garnett J. Sweeney, M.D., Liberty, new president of the Kentucky Academy.

Silver Jubilee for Hospital Ass'n Features Doctor Buerki

Robin Buerki, M.D., executive director of the Ford Hospital, Detroit, Michigan, was the guest speaker at the Annual Dinner Meeting of the Kentucky Hospital Association held during the Silver Jubilee Convention in Louisville, April 20, 21, and 22.

Edward W. Horgen, Ashland, took office as new president of the KHA, succeeding Miss Helena R. Hughes, retiring president. John B. Buschemeyer, Louisville, General Hospital administrator, was selected as president-elect.

President of the KSMA, J. Duffy Hancock, M.D., Louisville, represented the association as a guest at the Speaker's Table at the Annual Dinner. Participating on the program were two KSMA members, Clyde C. Sparks, M.D., Ashland, president-elect, and M. J. Henry, M.D., Louisville, president of the Kentucky Chapter of the American College of Surgeons.

ADA Appoints Dr. Morse to Serve Two Positions

Twin honors were bestowed on Carlisle Morse, M.D., Louisville, by the American Diabetes Association during the month of April. He was appointed to serve as Governor of the American Diabetes Association for the state of Kentucky, according to J. Richard Connelly, New York, executive director of the ADA.

Dr. Morse also accepted an office of vice chairman of the Committee on Detection and Education of the American Diabetes Association for the year 1954. Randall G. Sprague, M.D., New York, president, who made the announcement, added that membership of the Committee totaled 39.

Districts 12, 15 to Meet July 14 At Cumberland Falls

Du Pont Lodge at Cumberland Falls has been chosen as the site for the annual joint meeting of the Twelfth and Fifteenth Councilor Districts of the KSMA, the afternoon and evening of Wednesday, July 14.

J. Duffy Hancock, M.D., Louisville, KSMA president, is among speakers to be featured at this session according to a joint statement by 12th District Councilor Garnett Sweeney, M.D., Liberty, and 15th District Councilor Edward Wilson, M.D., Pineville.

The scientific program had not been completed at Journal press time but indication was that a very profitable presentation was in the making. It was also indicated that the members were urged to bring their wives to this meeting. Each member will receive complete details on the meeting from the councilor of his district well in advance of the session.

District 4 Holds Annual Dinner At Hardin Memorial Hospital

Physicians and their wives of the Fourth Councilor District will hold their annual dinner meeting Wednesday evening, June 9, according to Keith Crume, M.D., Bardstown, councilor.

Highlights of the meeting will include an address by KSMA President J. Duffy Hancock, M.D., Louisville, a timely scientific program and a tour of the hospital. Hardin County Medical Society of which Edward J. Sharman, M.D., Elizabethtown, is president, will be the host group.

"Diarrhea in Infants," will be the title of the paper presented by James Bruce, M.D., Louisville, and "Recent Advances in the Prevention and Treatment of Acute Polio" will be discussed by Alex J. Steigman, M.D., Louisville.

Results Listed on 1st Yr.'s Study Of Physicians in Service

Fifty-one per cent of 3,948 physicians completing questionnaires after leaving active military service indicated they felt medical departments were adequately staffed, according to the first year's study recently issued by the AMA's Council on National Emergency Medical Service.

Twenty-nine per cent felt there was overstaffing and 20 per cent said understaffing was a factor in the questionnaire developed in an effort to improve the utilization of medical personnel and the formulation of a more effective voluntary officer procurement system.

The average time spent in service was found to be 24.5 months; average tour of duty in U.S., 7.6 months; average tour of foreign duty, 17.1 months. Answers to the question regarding the type of medical care provided for other than military personnel indicate that in the Army and Navy the most frequent type was outpatient care, while in the Air Force it was obstetrics and gynecology.

Of these physicians assigned to domestic duty, 53.4 per cent were engaged in treating military personnel, 28.3 per cent in treating

military dependents and 18.3 per cent in "other;" while of those assigned to overseas duty, 51.8 per cent treated military personnel, 23.18 per cent dependents of military personnel and 24.4 per cent "other."

Joint Commission of 5 Groups to Study Indigent Medical Care

Kentucky physicians will be interested in the announcement made in the April 21 issue of the Secretary's Letter from George F. Lull, M.D., secretary and general manager of the AMA, relating to the joint commission to study indigent medical care.

Representatives from five different groups, the American Hospital Association, the American Dental Association, the American Public Health Association, the American Public Welfare Association and the AMA have been conducting independent studies over the last few years and now plan to establish a liaison unit through which they can work together.

The KSMA Committee on Medical Service is currently conducting a survey in Kentucky on indigent medical care problems. It has been assisted in the effort by the AMA Council on Medical Service.

Hospitals Admit Record Number of Patients in 1953, Report Shows

Hospitals set a new record during 1953 with 19,869,061 patient admissions as compared with 18,914,847 in 1952, which shows a continued increase in the volume of hospital services in the country, according to the 33rd annual report prepared by the AMA's Council on Medical Education and Hospitals.

For the second time in history, the number of hospital births exceeded the three million mark—with 3,307,182, representing approximately 84 per cent of the estimated annual births in the U. S.

Another highlight of the study showed 6,840 hospitals were registered by the AMA—2,136 classified as governmental and 4,704 as non-governmental. Gains in patient admissions were noted in both groups but more pronounced in the non-governmental division credited with 74 per cent of all admissions.

Summer Vacations

Don't forget to let your patients know when you plan to be away on vacation. Explain the arrangements you have made for taking care of them during your absence.

Pediatric Postgraduate Course to Continue Through June 24

Continuing through June 24, the Pediatric Postgraduate Course which began May 6, will be held at the new Children's Hospital, Louisville. The sessions are being sponsored by the University of Louisville School of Medicine, the American Academy of Pediatrics and the Kentucky State Medical Association. Beginning at 9:30 a. m., the sessions last until 12:30 each day.

Following is the program of the course for the month of June:

Thursday, June 10

Dehydration and Starvation in Diseases of Childhood
William A. Brodsky, M.D.
Clinical Conference
Leonard T. Davidson, M.D.
Discussion by
Martin J. Harris, M.D.
Symposium on Advances in Pediatric Surgery
Hugh B. Lynn, M.D.

Thursday, June 17

Dehydration and Starvation in Diseases of Childhood (concluded)
William A. Brodsky, M.D.
Clinical Conference
Leonard T. Davidson, M.D.
Discussion by
Walter A. Kirchner, M.D.
Diagnosis and Therapy of Tuberculosis in Childhood
Joseph A. Little, M.D.

Thursday, June 24

Anemias of Childhood
Israel Diamond, M.D.
Clinical Conference
Leonard T. Davidson, M.D.
Discussion by
Selby V. Love, M.D.
Minor Pediatric Surgery
Hugh B. Lynn, M.D.

Secretaries PR Course Staged by Henderson, Daviess Counties

The public relations course for physicians' secretaries, developed by the Education Campaign Committee of the Kentucky State Medical Association, was presented for members of the Henderson and Daviess County Medical Societies during the months of May and June, it was reported by W. Vinson Pierce, M.D., Covington, committee chairman.

The course was held in Henderson on May 17, 24, and 31, with the assistance of the so-

ciety president, Darryl Vaughn, M.D., and the secretary, George Buckmaster, M.D., both of Henderson. Officer staff members and their physician-employers of Daviess County attended the PR meetings in Owensboro held on May 18, 25, and June 1, according to E. H. Warren, M.D., society president, and Clint M. Lacy, M.D., secretary, both of Owensboro.

"PR courses such as these are beneficial to secretary and physician alike and are available to any KSMA component medical society," Dr. Pierce said. Since so much of the physician's favorable public relations stems from the impression created by members of his office staff, the committee hopes that every KSMA medical society will plan to profit by such a course. Information may be obtained by contacting the Headquarters Office or the chairman of the Education Campaign Committee.

Radio-TV to Carry AMA Session

Kentucky physicians not planning to attend the AMA's 103rd Annual Session in San Francisco will be interested in viewing highlights of the meeting on their television screens, June 24, at 9 p. m. (CDT), over the NBC network. This is the third in the 1954 Spring Series of "March of Medicine" live telecasts, sponsored by Smith, Kline and French Laboratories in cooperation with the AMA.

On the radio network of the American Broadcasting System, for the fifth consecutive year, the installation of the new AMA President, Walter B. Martin, M.D., will be broadcast nationwide on Tuesday night, June 22, at 9:30 p. m., (CDT). After taking the oath of office, Dr. Martin will deliver a timely report on medical progress in his inaugural address.

Speaker's Kit Given With VA Films

A new pocket-size speaker's kit containing commentary on a series of 17 color film strips on veterans' medical care is now available from the AMA through the KSMA Headquarters Office for showings at county medical society meetings, according to Daniel L. Bower, M.D., chairman of the KSMA Veterans Committee.

Aspects of the veterans' care problem discussed in these slides include types of disability, analysis of trends in veteran population, VA hospital beds, the increasing tax burden and the medical profession's policy on the subject. Each panel of the film strip is reproduced in the bound kit, and pertinent facts are keyed to correspond to the film.

Association Presidents to Convene

The Conference of Presidents and other Officers of State Medical Associations will be held June 20, 1954, at the Palace Hotel in San Francisco, California, preceding the AMA Meeting, according to G. Y. Graves, M.D., Bowling Green, member of the executive committee of the conference.

Highlights of the meeting include a panel discussion on "Doctors and the Press," from the points of view of a magazine editor, a science writer, and a physician; a discussion entitled, "Are Public Relations Programs Worth What They Cost?"

Fifty Attend 1st District Meeting

Approximately 50 physicians and guests attended the Annual Joint Dinner Meeting of the First Councilor District and the McCracken County Medical Society, held at the Ritz Hotel, Paducah, April 28, 1954, according to J. Vernon Pace, M.D., Paducah, councilor.

Dr. Pace expressed himself as being well satisfied with the program and the excellent attendance. Featured talks by J. Duffy Hancock, M.D., Louisville, KSMA president, and D. Woolfolk Barrow, M.D., Lexington, stimulated much interest among attending members. Keith Sloan, M.D., Paducah, president of the McCracken County Medical Society, presided over the evening program.

SMA to Convene in St. Louis

The twenty-one sections comprising the Southern Medical Association will represent every phase of medical and surgical practice at the forthcoming meeting to be held in St. Louis, Missouri, November 8-11, 1954.

A wide array of papers will be presented at Kiel Municipal Auditorium by the various sections of the association during the scientific sessions which collectively total forty-eight half-day sessions. A wealth of material will also be presented at the meeting in the form of scientific and technical exhibits. Members of the St. Louis Medical Society will act as the host group.

Dr. Llewellyn to Head Heart Group

John S. Llewellyn was elected president of the Louisville Heart Association at the annual meeting of the group in Louisville, April 21. He will take office July 1. One of the directors elected was Jack L. Chumley, M.D., Louisville, associate scientific editor of the Journal of the KSMA.

Pediatric Seminar to be Held

The 34th annual session of the Southern Pediatric Seminar, offering postgraduate summer courses in pediatrics, internal medicine, and obstetrics and gynecology, will be held July 12-31, 1954, in Saluda, North Carolina, according to Julian P. Price, M.D., dean. The American Academy of General Practice will accept credit for each hour of attendance.

UMWA Selects New Consultant

Appointment of Aims C. McGuinness, M.D., dean of the University of Pennsylvania Graduate School of Medicine, as Clinical Consultant for the new Memorial Hospitals of the United Mine Workers' Welfare and Retirement Fund, was recently announced by Josephine Roche, director.

The choice of Dr. McGuinness for the key position was based on his outstanding qualifications in the fields of clinical medicine, medical administration, medical education and professional relationships, according to Warren F. Draper, M.D., the Fund's Executive Medical Officer. Dr. McGuinness will assume his new duties about August 1, 1954.

Exhibit Shows 'Highway Killer'

Tragedy on the highway caused by Highway Killer Number Three—the drinking driver— is aptly depicted in a new exhibit, "Alcohol Tests for Drinking Drivers," which is now being offered to local medical societies by the AMA's Bureau of Exhibits.

Advantages and disadvantages of different methods of testing the drinking driver are visually demonstrated in this attractive exhibit, and a series of simulated windshields show the progressive changes in the drinking driver's vision through the four stages—sober, fuzzy, dizzy and drunk.

AMA Produces New TV Films

A new series of five-minute films illustrating in simple language what to do in an emergency before the doctor comes have been produced especially for television in local communities by the American Medical Association and are available on loan to local medical societies.

Subjects include: sore throat, contagious diseases in the home, accidents, the convalescent child, and cuts and bruises. Inquiries should be directed to the AMA Film Library, 535 North Dearborn, Chicago 10, Illinois.

Tenn. Elects New Executive Sec'y

Mr. Jack E. Ballentine, of Nashville, was recently elected the new Executive Secretary of the Tennessee State Medical Association at a called meeting of the Board of Trustees, February 14, 1954. He will assume office on June 1.

Mr. Ballentine has served as Executive Secretary of the Nashville Academy of Medicine for the past four years, and prior to his present position has had wide experience in public relations and organizational work. He was formerly connected with the Chamber of Commerce in Owensboro, Kentucky.

KSMA Roster Increased by 17

A cordial welcome is extended to the 17 physicians who recently became new members of the Kentucky State Medical Association. The following names have been added to the KSMA membership roster:

Glenn D. Baird, M.D., Bandana,
James S. Bates, M.D., Somerset,
E. S. Carter, Jr., M.D., Mayfield,
William E. Dean, M.D., Covington,
R. M. French, M.D., Lexington,
John R. Hill, M.D., Somerset,
Anne H. Hopwood, M.D., Somerset,
P. H. Isacco, M.D., Glasgow,
Ann H. Johnson, M.D., Owensboro,
Duncan G. Johnson, M.D., Owensboro,
R. E. Mardis, M.D., Madisonville,
W. V. Schulte, M.D., Lexington,
William B. Simpson, M.D., Mayfield,
Donald M. Stevens, M.D., Highland Heights,
R. L. Summer, M.D., Henderson,
Ross Vilardo, M.D., Jenkins,
Irvin Zevin, M.D., Cumberland.

Dr. Page to Address Heart Group

Irvin H. Page, M.D., Cleveland, one of the world's leading authorities on heart research, and president-elect of the American Heart Association, will speak on "Research in Heart Disease—A Challenge," at the luncheon session of the Kentucky Heart Association's annual meeting at the Roof Garden, Brown Hotel, Louisville, on June 10, 1954.

The appointment of Kenneth B. Babcock, M.D., Detroit, as director of the Joint Commission on Accreditation of Hospitals has been announced by Newell W. Philpott, M.D., Montreal commission chairman. Dr. Babcock will succeed Edwin L. Crosby M.D., newly-appointed executive director of the American Hospital Association.

Washington News Digest

Washington, D. C.—At the request of the Defense Department, Congress is considering a bill to expand and make more uniform the medical care program for civilian dependents of military personnel. It could have significant impact on the practice of medicine and on medical economics.

The legislation developed out of the Defense Department's Moulton Commission report of a year ago. In the intervening months the department's legislative planners called in representatives of the American Medical Association and other professional groups for advice. But the bill finally presented to Congress is evidence that not all differences of opinion were compromised. While in many respects the measure is in line with the policy of AMA on dependent care, at least one basic conflict remains:

The department's bill states that dependents should receive private medical care only when military facilities are unavailable or inadequate. The AMA's policy, adopted after long study of the problem, is that dependents should be cared for in military hospitals and by uniformed physicians only when civilian care is inadequate or unavailable.

There is almost complete agreement that the present patchwork dependent medical care program should be changed to make benefits uniform geographically and within the services, and to spell out the benefits in law. The issue is whether the military medical services should care for all qualified civilian dependents, or dependents should, like the rest of the population, get their medical care from civilian physicians and hospitals.

Under the bill, medical care furnished by or underwritten by the federal government would be limited to "diagnosis, acute medical and surgical conditions, contagious diseases, immunization, and maternity and infant care." Dental care would be allowed only in emergencies or as an adjunct to medical care. These restrictions would be waived overseas and at remote stations in the United States.

The definition of "dependents" would not extend beyond parents and parents-in-law, and these relatives would have to receive at least half their support from the military member to qualify.

The Secretary of Defense would decide what charges, if any, to levy against dependents treated at military facilities. When treated privately the dependents would pay the ,first $10 cost of any illness, plus not more than 10% of the total cost. The secretary could make use of voluntary health insurance for dependents if this system were found to be more economical.

The Senate Armed Services Committee was slow to take up the dependent care bill because of a heavy schedule of other hearings. Nor did it make fast progress in the House. There the introduction of the bill was delayed when Chairman Dewey Short (R., Mo.) called on Defense Department to furnish him with detailed information on what the new medical care program would cost.

By mid-May, when Congress had about concluded hearings on all major administration health bills, a new factor was introduced. Chairman Wolverton of the House Interstate and Foreign Commerce Committee called hearings on his own bill for federal guarantee of private loans to health facilities. This was not part of the original Eisenhower health program, but there were some indications that the administration might get behind it.

As originally drawn, the bill would virtually exclude all clinics and hospitals except those operated in conjunction with prepaid insurance plans. During the hearings, Mr. Wolverton indicated he would be willing to drop this restriction. If this were done the law then would offer benefits to all—fee-for-service physicians and groups as well as "closed panels."

During this period, some sentiment developed to combine the loan guarantee bill with the reinsurance bill, which wasn't making much progress on its own. The result was a period of confusion and uncertainty, with no clear indication of what either the committee or the administration really wanted.

A few other medically-important bills were advancing on schedule. The House Ways and Means Committee gave every indication of reporting out a bill to require all employers (physicians included) to participate in the federal-state unemployment insurance program. As usual moving faster than the Senate, the House had passed a bill to give state health officers more control over federal grants for public health work. The House also was nearing a vote on extension of the social security program, with no suggestion that physicians and other self-employed groups who don't want coverage would be exempted. The House-approved Hill-Burton expansion bill was waiting action in the Senate.

County Society Reports

CALLOWAY

Response to the Blue Cross and Blue Shield drive was reported to be favorable at the monthly meeting of the Calloway County Medical Society, held in the chapel of the Murray Hospital, March 1, 1954. The society decided to continue to run a small ad each month in the local paper.

A report was made on the physical therapy work being done with children afflicted by polio. The following physicians were present: A. D. Butterworth, Charles Clark, J. C. Hart, Hugh Houston, C. H. Jones, C. C. Lowry, O. K. Mason, J. A. Outland, John Quertermous, Kenneth Ross, and Administrator Warming.

J. L. Hopson, M.D., Secretary

GRANT

Branham Baughman, M.D., Frankfort, Councilor from the 7th District, discussed events of the County Society Officers' Conference and the meeting of the House of Delegates, April 15, with the members of the Grant County Medical Society at a dinner meeting April 26, at the Hotel Donald, Williamstown.

He described the talk given by Louis M. Orr, M.D., Orlando, Florida, who spoke on "Government Medicine, VA Style." Dr. Baughman also reported on the question of Negro physicians and the KSMA. He extended an invitation to attend the district meeting to be held at Frankfort in June.

A letter was read from the Cancer Society thanking the society for their cooperation in a Cancer Mobile Clinic held in March. In response to correspondence from the AMA requesting information on the program used for medical care of the indigent, it was stated that no formal plan exists but that each physician voluntarily assumes his share of the responsibility.

The society agreed that there should be an article in the county newspaper regarding Child Health Week, scheduled for the first week in May. Lenore P. Chipman, M.D., suggested that the society should plan some form of speakers bureau with each member turning in a subject they would be willing to discuss with a lay group.

O. Abbett Cull, M.D., president, appointed a committee to study the physicians placement service questionnaire and report on it at the next meeting. The Pediatric Post Graduate Course to be held in Louisville, beginning May 6, 1954, was announced.

Dr. Baughman said that Maurice Bowling, M.D., and Paul Harrison, M.D., of Owen County, would like to join with Grant County Medical Society for meeting. He said that each county would still send a delegate to the KSMA. This was agreed upon.

It was moved that Smith H. Gibson, M.D., be reimbursed for the five dollars he contributed in the name of the Grant County Medical Society for an advertisement in the local school's program for a Minstrel Show. However, it was moved that the practice of buying ads be discontinued in the future. Both motions carried.

Virginia D. Kratz, M.D., Secretary

JOHNSON

With the annual appearance of the Cancer Mobile Clinic in Paintsville, the members of the Johnson County Medical Society devoted the program of their dinner meeting, April 1, at the Hotel Hearld, to the subject of cancer.

Guest speakers were Jack Floyd, M.D., Lexington, who spoke on "Breast Tumors," and Herbert H. Ransdell, Jr., M.D., Louisville, who discussed "Cancer of the Lung," showing a film on early diagnosis and expected results from early surgery of the lung.

The society always welcomes the clinic to their county once a year, with the members cooperating as fully as possible. Members express their thanks to Dr. Floyd and Dr. Ransdell for an excellent clinic and also program for the meeting.

Regular meeting time is the last Tuesday in the month with the exception of June, July, August, and December when meetings are not held.

The following physicians were present at the meeting: Paul B. Hall, Robert A. Hall, Charles L. Preston, Harry Overby, F. M. Picklesimer, Williams Keith, A. D. Slone, and the following dentists: G. P. Salyers, G. V. Stafford, Howard L. Meade, and J. H. Rapier.

A. F. Williams and T. E. Walden, optometrists, were present. Other guests were Herman Meredith, technician; Miss Rae Riley, R. N.; Mrs. Lola Belle Akin, R. N.; Mrs. Freda Willoughby, of the local health department; Miss Fannie Blankinship, Angie Sammons, and May L. Preaton, nurses of the Paintsville Hospital.

Augustus D. Slone, M.D., Secretary

SCOTT

L. B. Mezera, M.D., Louisville, head of the Maternal and Child Welfare Department of the State Department of Health, presented a discussion on the immunization of children at the monthly meeting of the Scott County Medical Society, May 6, at the John Graves Ford Memorial Hospital, Georgetown.

Dr. Mezera said that the use of one per cent silver nitrate solution in a new-born baby's eyes is mandatory and urged that the health nurses be asked to visit the mother and baby after they have left the hospital and report conditions found in the home to the doctor.

He urged the society members to give the triple vaccine and smallpox in the first year of the child's life and also to give booster shots every 2 years. He said that these shots should be reported to the Health Department. Dr. Mezera felt that it was safe to continue vaccinations throughout the summer months.

Mr. B. C. Johnson, director of the Scott County Health Department, was also a guest of the society. The followng physician-members of the society attended: W. S. Allphin, C. R. Lewis, H. P. Crutchfield, E. C. Barlow, A. F. Smith, F. W. Wilt, H. G. Wells and H. V. Johnson.

H. V. Johnson, M.D., Secretary

McCRACKEN

A combined dinner meeting of the McCracken County Medical Society and the First Councilor District met April 28, at the Ritz Hotel, Paducah, with W. K. Sloan, M.D., presiding.

KSMA President J. Duffy Hancock, M.D., Louisville, addressed the society regarding some of the problems confronting organized medicine. Following Dr. Hancock's talk, the scientific program was conducted by David W. Barrow, M.D., Lexington, who spoke on the subject, "Varicose Veins and Their Complications." Questions and discussion followed.

At the business session a letter relative to immunization week from C. C. Howard, M.D., was read and discussed. Winfield Stryker, M.D., was appointed to read a prepared program for re-broadcast on tape.

The activities of the Fourth Annual County Society Officers' Conference in Lexington were discussed by Doctors Pace and Sloan and Mr. Joe Sanford, KSMA executive secretary.

M. W. Fowler, M.D., reminded members of the society that a greater number of participating physicians in the association of commerce would probably improve public relations.

M. W. Fowler, Jr., M.D., Secretry

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Amebiasis[1] a "Poorly Reported" Disease

Until serious complications arise, amebiasis may pass unrecognized and patients receive only symptomatic treatment.

Although amebiasis is a disease with serious morbidity and mortality, statistics on its incidence[1] are incomplete because its manifestations are not commonly recognized and consequently not reported.

"*Vague symptoms[2] referable to the gastrointestinal tract, such as indigestion or indefinite abdominal pains, with or without abnormally formed stools, may result from intestinal amebiasis. Not infrequently in cases in which such symptoms are ascribed to psychoneurosis after extensive x-ray studies have been carried out, complete relief is obtained with antiamebic therapy.*"

To prevent possible development of an incapacitating or even fatal illness and to eliminate a reservoir of infection in the community, diagnosing and treating[3] even seemingly healthy "carriers" and those having mild symptoms of amebiasis is advised.

Early diagnosis[1] is important because infection can be rapidly and completely cleared, with the proper choice of drugs and due consideration for the principles of therapy. For treatment of the bowel phase these authors find Diodoquin "most satisfactory."

For chronic amebic infections, Goodwin[4] finds Diodoquin to be one of the best drugs at present available.

Diodoquin, which does not inconvenience the patient or interfere with his normal activities, may be used in the treatment of acute or latent forms of amebiasis. If extraintestinal lesions require the use of emetine, Diodoquin may be administered concurrently. It is a well tolerated and relatively nontoxic orally administered amebacide, containing 63.9 per cent of iodine.

Diodoquin (diiodohydroxyquinoline), available in 10-grain (650 mg.) tablets, reduces the course of treatment to twenty days (three tablets daily). Treatment may be repeated or prolonged without serious toxic effect. It is accepted by the Council on Pharmacy and Chemistry of the American Medical Association. G. D. Searle & Co., Research in the Service of Medicine.



Endamoeba histolytica (trophozoite).

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LOUISVILLE, KENTUCKY

COUNTY SOCIETY REPORTS

(Continued from Page 458)

UNION

Harold Kleinert, M.D., member of the staff at the University of Louisville School of Medicine, headed a discussion of the treatment and diagnosis of Pancreatitis and Hepatitis at the monthly meeting of the Union County Medico-Dental Society, February 17, at Our Lady of Mercy Hospital, Morganfield.

On January 19, 1954, the society heard Gilbert T. Hyatt, M.D., Evansville, Indiana, speak on "Treatment of Fractures in General." A question and answer session developed after the talk and Dr. Hyatt offered advice requested on local cases.

C. P. Bartley, M.D., Secretary-treasurer

WARREN-EDMONSON

William Hillman, M.D., of Vanderbilt University School of Medicine, discussed lesions of the cervical spine and upper extremity pain at a meeting of the Warren-Edmonson County Society, February 9, 1954, with R. O. Green, M.D., president, presiding.

At the regular meeting on March 9, 1954, the society decided that the cancer and heart clinics at Bowling Green City Hospital be limited to medically indigent patients as stated by the referring physician.

A. D. Donnelly, Sr., M.D., and Hunter Gingles, M.D., were placed on the honorary membership roll of the society.

Charles M. Francis, M.D., Secretary

SPRING FASHIONS

(Continued from page 443)

dicated for the prevention and control of atherosclerosis. The styles influenced by medical opinion change again but now in the direction of the fashions of several years ago. Any diet that produces obesity is a diet that will further atherosclerosis; the best preventive and the best treatment is the maintenance of normal or slightly subnormal weight. Adequate control of obesity—public enemy number one and public health problem number one—seems to be the best and most logical approach to the prevention and treatment of atherosclerosis.

JOHN S. LLEWELLYN, M. D.
Louisville

Fear of not getting enough sleep, drilled into an individual from childhood, can keep an individual awake nights, according to an article in the AMA's Today's Health magazine.

CASE DISCUSSIONS

(Continued from page 438)

require no elaboration here. Experience has demonstrated that in some cases acute complications may be aborted by the use of effective antibiotics, and that inflammatory masses and partial colonic obstruction may respond to conservative measures alone. Operative treatment is imperative in the management of such complications as free perforation into the peritoneal cavity, fistulas, and complete or near-complete obstruction."

Dr. James C. Drye, Department of Surgery

"This case is a little unusual in that there was such a small number of diverticula present. However, it is a good illustration of one of the common complications of diverticulitis and demonstrates well the proper management of that type complication.

Historically, the operative treatment of diverticulitis was regarded as an unfortunate necessity and relegated to a position of last resort to be used only after failure of medical treatment. Modern surgical technique and better understanding of the principles of patient care have now made safe the operative treatment of colonic disease. There no longer seems to be any good reason for avoiding a diverting colostomy early in the course of a very acute diverticulitis for this, and this alone, will provide rest for the inflamed area. The colon is no exception to the rule that subsidence of inflammation is best promoted by rest. Further, the increasing safety and lower morbidity and mortality of colonic resection now make it advisable to carry out elective excision of localized areas of diverticulitis to spare these patients the invalidism associated with constantly recurring attacks of diverticulitis with all their associated complications and hazards.

This attitude is well-expressed by Dr. Evarts Graham, Editor of the Yearbook of Surgery, following his abstract of several recent papers advocating early surgery.....'The general tone of all the preceding five articles is for early resection of the involved colon in a case of diverticulitis. This attitude is thoroughly sound in view of the comparative safety of the operation nowadays. The old policy of watchful waiting is becoming untenable.' "



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BUTTON HOLE INCISION

(Continued from page 436)

cases where spillage has been excessive or where the peritoneal fluid appears purulent. The post-operative care is that used in any case of peritonitis and nothing is given by mouth until peristalsis has returned to normal.

We have used this method in treating 17 cases of perforated duodenal ulcer during the past three years and have been very much pleased with our results. There have been no deaths. The average hospital stay has been five days. There have been only three minor wound infections and no disruptions.

We feel that the small incision is a definite asset in the management of this condition. The small incision can always be enlarged to suitable proportions if need be, and, of course, one should not struggle to do the operation through a small incision if a larger incision is indicated.

Summary

A small incision usually affords exposure, reduces operating time, is easier on the patient and minimizes wound complications, pulmonary complications and thromboembolic complications, thereby reducing the hospital stay and the mortality rate.

We always emphasize that simple closure of an ulcer must be followed by definitive surgery for permanent eradication of the ulcer. The minimal reaction associated with the small incision makes it possible to perform this definitive surgery within four to six weeks.

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Today, a woman has better than 999 chances out of 1,000 of coming through childbirth safely, according to the American Medical Association. A woman's chances of surviving childbirth are eight times better than were her mother's.

Blue Shield, formed in 1949 by the physicians of Kentucky, in 1953 paid $1,388,266 to physicians in surgical-medical benefits. This fact may be used in responding to those who assert that physicians are against socialized medicine but are not providing something to help the public meet their medical expenses.

THE MEDICAL PROBLEMS OF THE LOW INCOME GROUP

(Continued from page 441)

happen under federal participation in the general field of medicine.

The physicians of this country have a great responsibility. We have declared in the constitution of our national medical organization that our purpose is the advancement of the science and art of medicine, and the betterment of the public health. There are large groups of people in this country who, by reason of ignorance or financial inability, are unable or unwilling to purchase hospital protection on a pre-payment basis. The question arises who will pay for the cost of their illness at the time that their illness occurs. We feel that this is local and state responsibility.

We as physicians are better able than others to recognize the importance of making good medical care available to all members of a community. We also know that good facilities cannot be provided without proper financial support, and that inadequate facilities will be reflected in the quality of medical service received by all members of the community, whether rich or poor. It is our duty, therefore, as individuals and as organizations, local, state, and national, to use our influence to extend sound voluntary pre-payment programs, and to urge the proper financing of the health care of the lower income group at the local level. Two things are required of us. We must stimulate a sense of local responsibility for the medical care of the individual unable to purchase insurance and we must preserve the financial integrity of the voluntary pre-payment system by guarding against abuse and overuse.

The 32nd annual scientific and clinical session of the American Congress of Physical Medicine and Rehabilitation will be held September 6-11, 1954, at the Hotel Statler, Washington, D. C., it was recently announced by Walter J. Zeiter, M.D., executive director. In addition to the scientific session, annual instruction seminars will be held, Dr. Zeiter said. Full information may be obtained through the KSMA Headquarters Office.

There are 220,040 physicians in the United States today, 156,433 of whom are in active practice. On the basis of an estimated population of 160,000,000 in 1953, there is one physician actually engaged in practice of medicine for every 1,000 persons, according to a release on the subject from the AMA.

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In Memoriam

JOHN W. DUKE, M.D.

Hindman

1874 - 1954

Dr. John W. Duke, 80, of Hindman in Knott County, died April 16, 1954, shortly after suffering a heart attack at his home. Dr. Hindman was graduated from the Kentucky School of Medicine in 1896. He was a former member of the Hindman Settlement School's Board of Trustees.

THADDEUS H. HARDESTY, M.D.

Louisville

1862 - 1954

Dr. Thaddeus H. Hardesty, a former medical circuit rider in Kentucky for 53 years, died at the age of 92 at his home in Louisville where he had lived since his retirement in 1947.

Dr. Hardesty started riding the medical circuit on horseback at Paynesville and St. Mary, Kentucky, in 1894, soon after his graduation from the Louisville Medical College. During the last 35 years of his practice he relied upon the automobile for his transportation.

From 1916 to 1919 he was in the Medical Corps of the United States Army and stationed at Ft. Knox. For the next 28 years he practiced at St. Mary until he retired seven years ago.

The Hebrew Medical Journal is commemorating its twenty-sixth anniversary by issuing two volumes under the editorship of Moses Einhorn, M.D., of New York. Written in Hebrew, with English summaries, the Journal has played an important part in the creation of a medical literature and terminology in the language of the Bible.

The first 3-Dimension teaching film illustrating ambulatory rectal surgery was presented by the International Academy of Proctology at a recent Motion Picture Teaching Seminar at the Palmer House, Chicago. Surgical techniques as performed in the office, without hospitalization, are illustrated in this film.

Pertinent Paragraphs

Fount Richardson, M.D., Fayetteville, Arkkansas, recently became the new editor of the Journal of the Arkansas Medical Society, according to an announcement by the Executive Secretary Paul C. Schaefer, Fort Smith, Arkansas. Dr. Richardson succeeds W. R. Brooksher, M.D., who resigned as editor after twenty years of service.

The Senate Finance Committee, which has been holding extensive hearings on the income-tax revision bill passed by the House, has received the AMA's endorsement of the section increasing medical expense deductions. The bill would allow a taxpayer to deduct medical expenses in excess of three per cent of adjusted gross income instead of the present five per cent.

William S. McNary, representing both the American Hospital Association and the Blue Cross Commission, endorsed the proposed Health Insurance Fund at a hearing of the United States Senate Labor and Public Welfare Committee's health subcommittee. Mr. McNary said that this legislation may bring the voluntary pre-payment goal nearer and advocated that further study be made to find a source of funds for coverage of groups not able to pay for their own protection.

A pilot experiment in using color in some text illustrations is being tried by the New York State Journal of Medicine in the belief that this will further modernize and make the publication more attractive. This is believed to be the first such use of color illustrations in the text by any state medical journal in this country.

Roentgen diagnostic procedures produce a very high percentage of correct tumor localization, according to a ten year study made at the University of Michigan in the Department of Roentgenology and Department of Surgery. A report on the study based on 750 authenticated brain tumors was published in the April issue of the Journal of "Roentgenology, Radium Therapy and Nuclear Medicine."

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Local draft boards are again processing physicians for induction under the Doctor Draft act in accordance with instructions issued from Selective Service Headquarters on March 24, 1954, it was recently reported from the AMA Washington Office. For the first time since last August boards will resume processing for physical examinations and induction of priority 1 and 2 physicians of all ages, priority 3 physicians born after August 30, 1922, and priority 1, 2, and 3 dentists of all ages.

Booklets containing a compilation, by state, of pertinent information on all types of medical scholarships and loan funds are now available and may be obtained on request from the AMA Council on Rural Health.

BOOK REVIEWS

THE HISTORY OF THE MEDICAL DEPARTMENT OF THE UNITED STATES NAVY IN WORLD WAR II, Vol. I, United States Government Printing Office, Washington, D. C., 1953.

This history was written by 37 naval officers and covers a great variety of subjects, from "Experiences in Battle....," beginning with Pearl Harbor to "Malnutrition in Repatriat Prisoners of War."

The dry language of the book never dr matizes the heroism and the labor of the m who lived this history. No "playing up" needed. The immense stupidity, suffering, fru tration and confusion of warfare is well enou presented just by the record this is. This ov all picture is accented with occasional clos ups such as: "Landing with the troops—t chief pharmacists mate was shot in the jaw he stepped out of the landing boat," and ".. the worst blow came when the boat carryi all the litters was sunk on the way in." "A corpsman.....buried the lower part the Captain's body in the sand so that he wou offer a smaller target for the Jap riflemen. helped, but the Captain died later...."

A great many photographs illustrate the h tory and point up the dangers and difficult encountered in this vast effort. The statist and tables given are not in excess.

The book should be of considerable inter to those who served in the Medical Departme of the Navy and might well serve a larger us ful purpose in jolting some of the too co placent.

Reviewed by Jack Chumley, M.D., Louisville.

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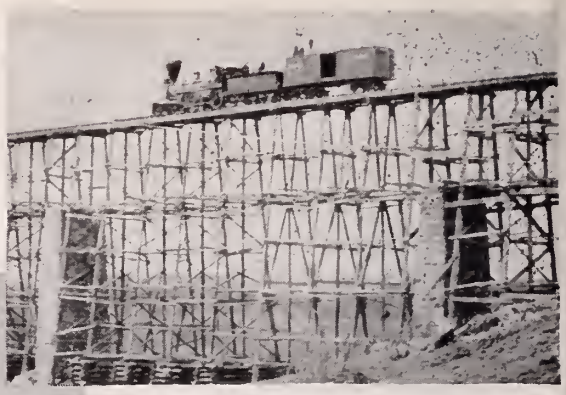
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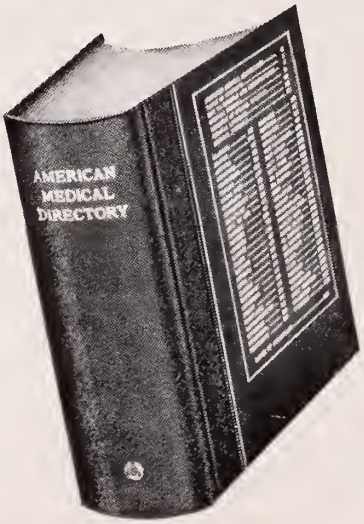
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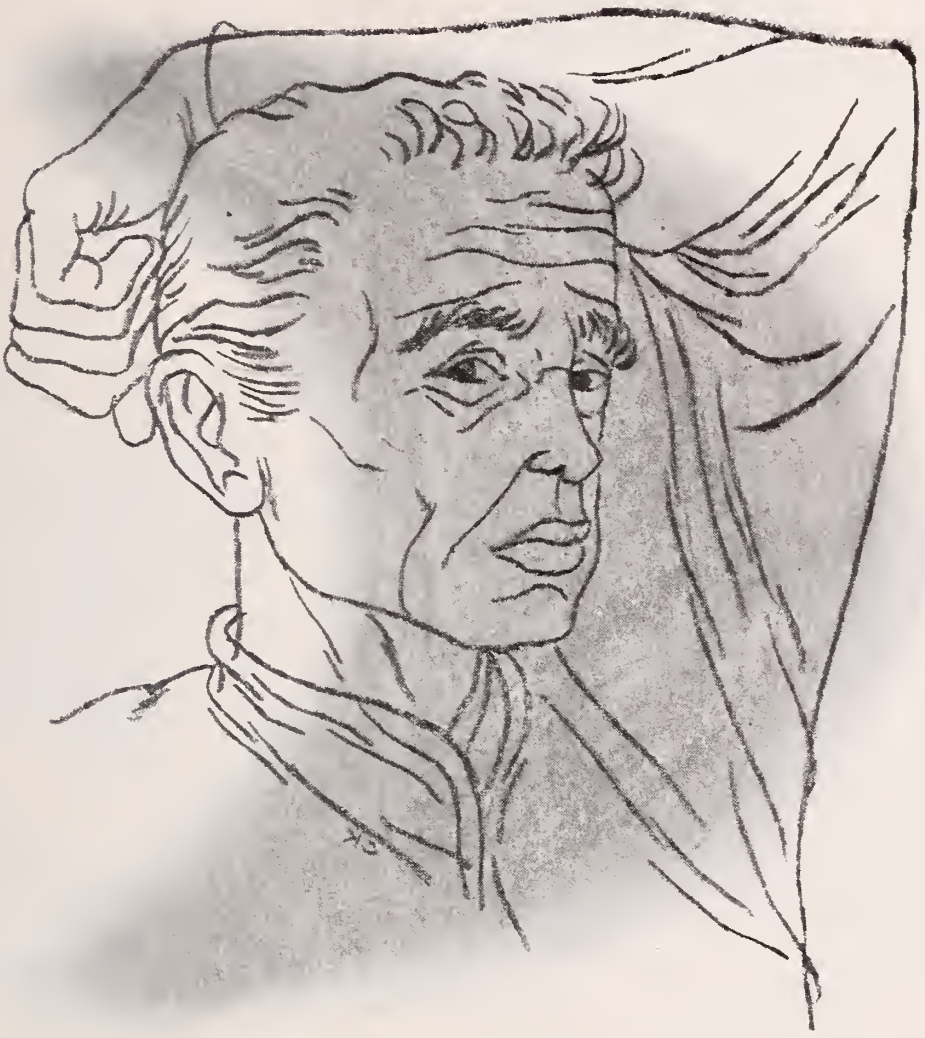
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1. Gurdjian, E. S., and Webster, J. E., Amer. J. of Surgery, 63:236, 1944.

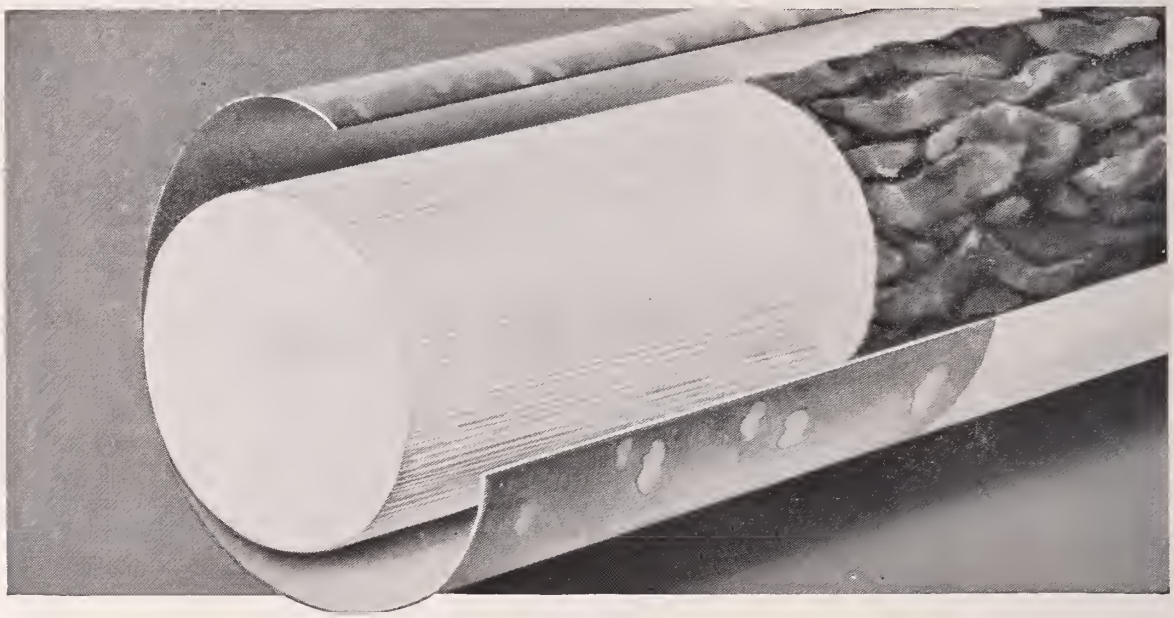
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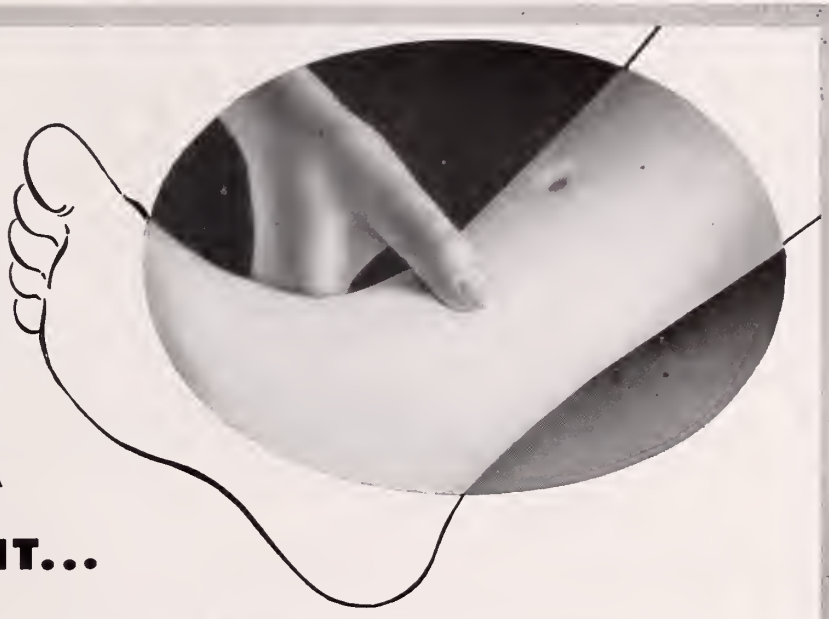


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1. Abramson, Julius, Bresnick, Elliott, and Sapienza, P. L.: *New England Jour. Med.*, 243:44, July 13, 1950.

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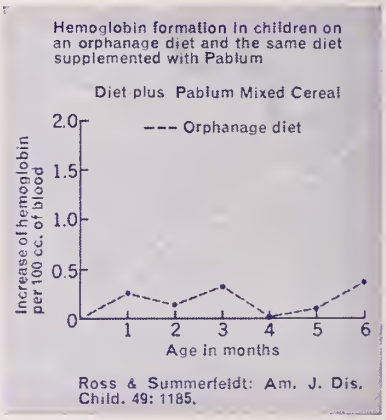
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1. Smith, N. J., and Rosello, S.: J. Clin. Nutrition 1: 275, 1953;
2. Jeans, P. C., in A.M.A. Handbook of Nutrition, ed. 2, New York, Blakiston, 1951, p. 280.

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If the patient complaining of aching joints is a woman between 37 and 54 years of age, it is highly possible that she is suffering from arthralgia rather than arthritis.[1] It has been estimated that arthralgia occurs in about 10 per cent of women with estrogen deficiency, and is exceeded in frequency only by symptoms of emotional or vasomotor origin.[2] In fact, arthralgia may be as indicative of declining ovarian function as the classic menopausal hot flushes.

Arthralgia, however, is just one of a vast number of distressing but ill-defined symptoms that may be precipitated by the loss of estrogen as a "metabolic regulator." Other good examples are insomnia, headache, easy fatigability, and tachypnea.

Because these symptoms sometimes occur years before or even long after cessation of menstruation, they are not always readily associated with estrogen deficiency, and the tendency may be to treat them with medications other than estrogen. Obviously, sedatives and other palliatives cannot be expected to produce a satisfactory response if an estrogen deficiency exists. Only estrogen replacement therapy will correct the basic cause of the disorder.

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1. Greenblatt, R. B., and Kupperman, H. S.: M. Clin. North America *30*:576 (May) 1946. 2. McGavack, T. H., in Goldzieher, M. A., and Goldzieher, J. W.: Endocrine Treatment in General Practice, New York, Springer Publishing Company, Inc., 1953, p. 225.

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1. Heller, E. M.: The Treatment of Essential Hypertension. *Canad. Med. Assn. Jour.*, 61:293, Sept., 1949.

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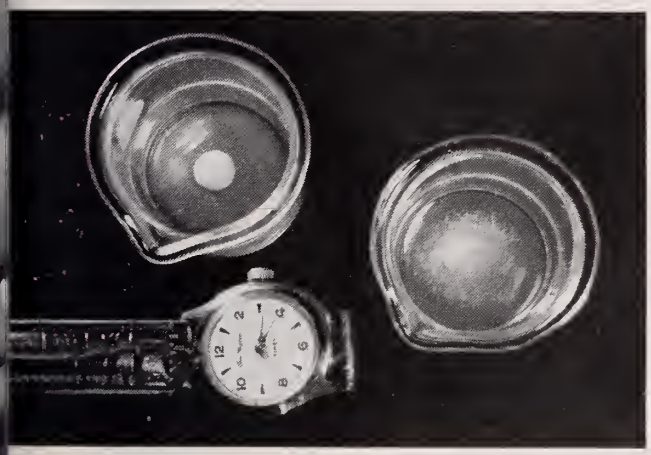


3:15—Disintegration Test begins in actual stomach fluids (pH 2.7). Beaker at left contains ordinary enteric-coated erythromycin. At right is new *FILMTAB ERYTHROCIN Stearate (Erythromycin Stearate, Abbott).**

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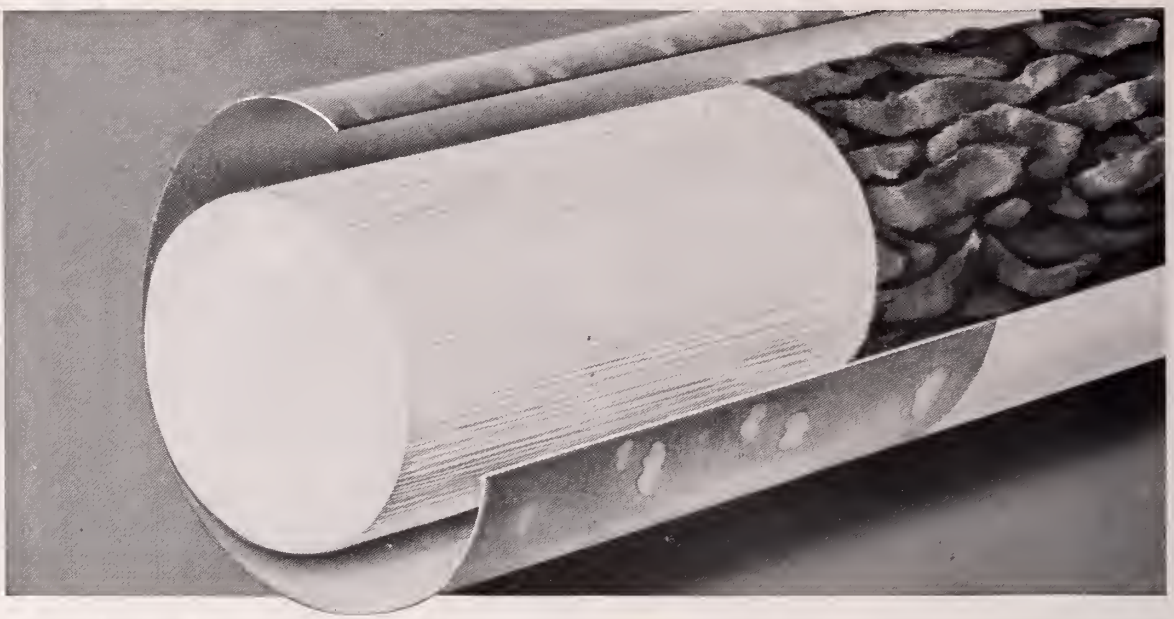
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*Kirsner, J. B.; Brandt, M. B., and Sheffner, A. L.: Diet and Amino Acid Utilization in Gastrointestinal Disorders, J. Am. Dietet. A. 29:1103 (Nov.) 1953.

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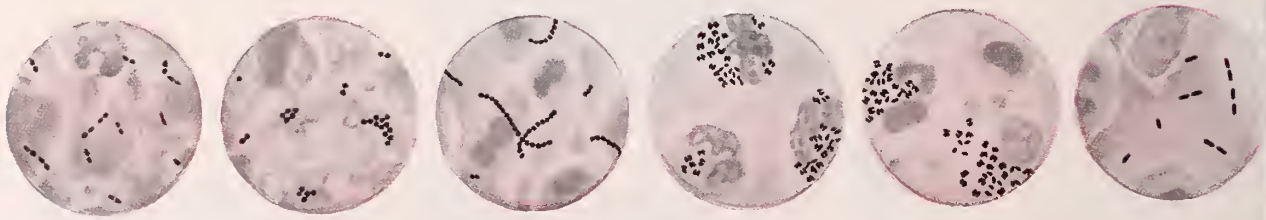
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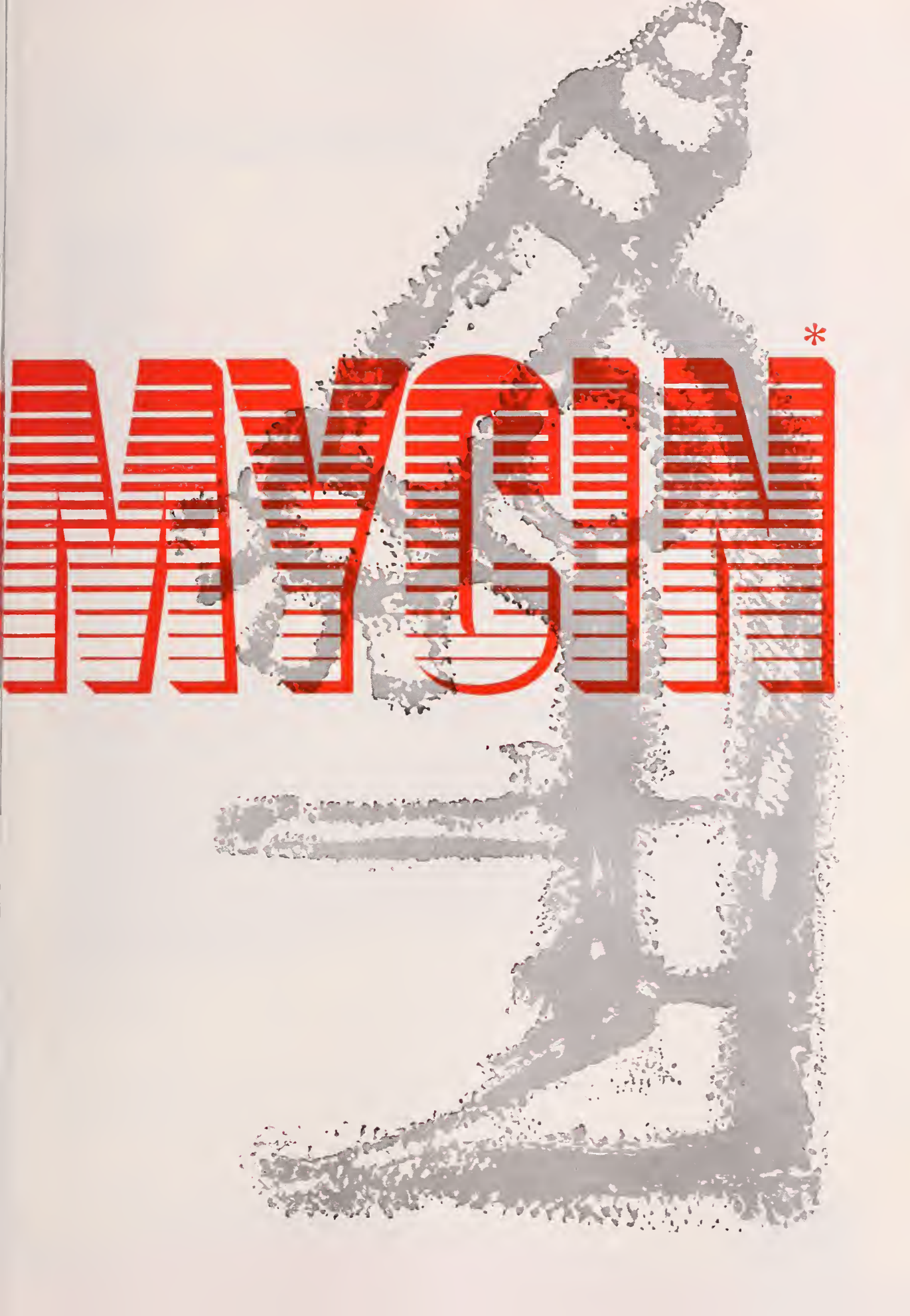
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1. Kauntze, R., and Trounce, J.: Treatment of Arterial Hypertension with Veriloid (Veratrum Viride), Lancet 2:1002 (Dec. 1) 1951.
2. Wilkins, R. W.: Combination of Drugs in the Treatment of Essential Hypertension, Mississippi Doctor *30*:359 (Apr.) 1953.
3. Stearns, N. S. and Ellis, L. B.: Acute Effects of Intravenous Administration of a Preparation of Veratrum Viride in Patients with Severe Forms of Hypertensive Disease, New England J. Med. *246*:397 (Mar. 13) 1952.
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	Mild	*Moderate*	*Total*
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Dihydrostreptomycin	6	0	6
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	Cochlear damage % of patients		
	Mild	*Moderate*	*Total*
Streptomycin	0	0	0
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**Heck, W.E.; Lynch, W.J., and Graves, H.L.: Acta oto-laryng. 43 416, 1953.*

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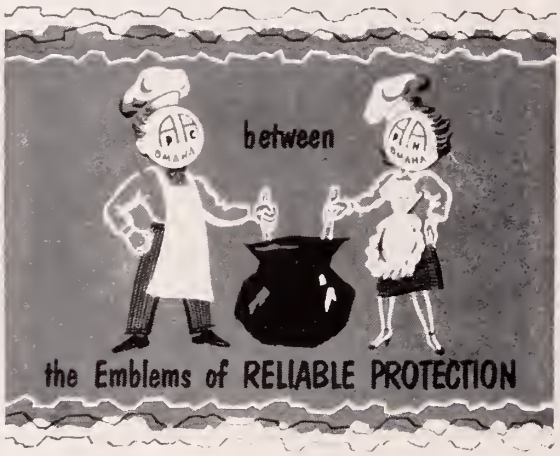
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The JOURNAL of the
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Issued Monthly Under the Direction of the Council
VOL. 52 JULY, 1954 NO. 7

Atherosclerosis

WILLIAM A. BLODGETT, M.D.
Louisville

The purpose of this paper is to discuss the subject of atherosclerosis in rather broad outlines stressing the present status of the blood lipids in the genesis of this disease. Out of the confusion which has resulted from the conflicting results of clinical studies and animal experiments, one can discern certain trends of thought which indicate that part of the disorder at least is a disturbed lipid metabolism.

Atherosclerosis can be thought of as disease rather than an inevitable part of the aging process. When we use the term, we do not refer to the lesion that one can feel by taking the pulse at the wrist of an aged person. The rigid, beaded structure felt here is the end result of a process of necrosis and calcification in the media of the major arteries and is known as Monckeberg's arteriosclerosis. Neither do we refer to the lesion found in the arterioles of the kidney in malignant hypertension. This is called arteriolar nephrosclerosis and consists of a hyperplasia of the intima of the arterioles without lipid deposition. Atherosclerosis is a degenerative disease which begins under the intimal lining of the large and medium sized arteries and results in the formation of plaque-shaped lesions composed of cholesterol, phospholipids, neutral fat, and cellular debris. As the lipid deposit increases in size, there may be necrosis and calcification of the deeper layers of the artery; and there may be ulceration of the overlying intimal membrane leaving a rough base on which thrombus formation is a frequent occurrence.

The lesions occur with great frequency in the major arteries to the heart, to the brain, to the extremities, and in the aorta. Why the lesions occur at these sites and spare other areas is unknown, as is the mechanism of their formation. It has been suggested that they are formed at points of physiological stress where blood pressure against the arterial wall is relatively increased and the blood lipids gain access to the arterial wall by direct filtration across the intimal membrane due to this increased pressure. The end result of the atherosclerotic lesion will depend on its location, since interruption of blood flow to the organ supplied is the only way in which the lesions express themselves. The inability to detect the presence of the lesions and to measure the extent of the process has been one of the greatest limiting factors in the study of the disease in man. While the concrete evidence offered by an attack of myocardial infarction or a cerebral thrombosis is good evidence that atherosclerosis exists, it gives no indication in a living subject of the extent of the disease or its rate of progression. For this reason direct studies of the disease have depended on experimental animals—realizing that man is unique among the mammals in that he is the only one in which atherosclerosis develops naturally. Studies in man have had to be based on a tangential approach using the circumstantial evidence inherent in the natural history of the disease and such chemical evidence as can be found by studying various elements in the blood and tissue.

Evidence Concerning Lipids

In discussing the role of blood lipids it would be of interest to mention some of the circumstantial evidence which has focused attention on them. As mentioned previously the lesion itself is characterized by deposits of lipid material in the

arterial wall. Analysis of this material has revealed it to be composed of the same lipids present in the plasma. Cholesterol is present in the greatest amount but the others—phospholipid and neutral fat—are also represented. In addition to this is the fact that certain diseases characterized by high levels of blood cholesterol have long been known to predispose to extensive and early atherosclerosis. Nephrosis, diabetes, and familial xanthomatosis are the best examples of this. Next, one can point to the fact that individuals and groups of individuals who habitually have a high dietary intake of cholesterol, or perhaps more important, the dietary precursor of cholesterol—show earlier and more extensive atherosclerosis than do those with a more moderate dietary history. Attention has been particularly focused on the American male in this regard. Keys has shown that over an age range of 30 to 70 years, the death rate in the white American male is higher than in many other countries and that this is accounted for by an excessive incidence of degenerative heart disease. Data on the national diets shows a striking association between total fat consumption and cardiac mortality among men.

Dock has compared the mortality rates from myocardial infarction in the American and British armies in England prior to the invasion of Europe and found that the much higher incidence in the American Army correlated well only with the difference in dietary fat. Many studies on populations in occupied countries have shown striking decreases in atherosclerotic diseases during periods of semi-starvation with a return of these diseases to the expected level when alimentation returned to normal at the close of World War II.

On the individual level, obesity has been associated with higher mortality rates due to various types of health impairment—atherosclerotic disease among them. Furthermore, obesity has been found to be accompanied by significant elevations in certain of the blood lipids.

Finally, one of the strongest pieces of circumstantial evidence pointing toward the blood lipids—and especially cholesterol—has been the fact that in certain animals who are otherwise free of naturally occurring atherosclerosis it has been possible to produce atherosclerotic lesions very similar to those occurring in man by the feeding of cholesterol. The chicken, rat, rabbit and dog have been most widely used.

Metabolism of Lipids

The study of blood lipids in relation to the atherosclerotic process revived interest in their normal metabolism. Until relatively recently it was thought that cholesterol was derived largely, if not entirely, from the ingested preformed cholesterol of the diet. It is now known that most of the body cholesterol is formed from simple carbon compounds, chiefly acetate, which is the end product of the breakdown of fatty acids. To some extent acetate is also derived from amino acids and carbohydrates as well. Thus, the building blocks are present in any diet, and the cholesterol produced by daily synthesis is two or three times greater than that contained in a diet generous in cholesterol. Because of the need for maintenance of plasma colloid relationship, both esterified and free cholesterol do not circulate in the plasma in molecular solution but in more or less discrete combination with certain of the plasma proteins—forming lipoproteins—the so-called giant molecules.

This applies also to all or virtually all of the plasma phospholipids including the lecithins, the sphingo-myelins and the cephalins. To a lesser degree it applies to the neutral fats.

These lipoproteins so constituted can be separated by electrophoresis into alpha lipoproteins and beta lipoproteins; by ultra-centrifugation they can be separated into a whole series of lipoprotein complexes of varying cholesterol, phospholipid, neutral fat and protein content.

There is good reason to believe that the lipoprotein molecules are held in colloidal suspension in the plasma in delicate balance, the upsetting of which allows the precipitation of the various elements in the tissues. There is also good evidence that the tissues themselves may be important sources of the production of phospholipids. Tracer studies using P^{32} in dogs have shown that the phospholipid present in the aorta of the dog made atherosclerotic by the feeding of cholesterol and thiouracil is largely synthesized in the aorta itself.

Of the ultimate fate of cholesterol in the body very little is known. The amount excreted as degradation products accounts for only part of the total and some of these are resorbed to be used in the synthesis of more cholesterol.

At the present time most attention centers about four different aspects of lipid

metabolism in relation to clinical atherosclerosis. These are cholesterol itself, the cholesterol-phospholipid ratio, the alpha and beta lipoproteins, and the Sf lipoproteins of Gofman.

Historically cholesterol was the first of the lipids to be extensively studied. The weight of evidence has indicated that in human atherosclerosis the blood levels tend to be elevated. This elevation may vary in amount and may be intermittent in its occurrence, and it is not known whether a constant elevation is any more important than the intermittent elevation which has been found to occur in various stress producing situations, such as acute infections. Since it was believed that dietary cholesterol was the chief source of body cholesterol, an era of cholesterol limitation was entered upon in the management of clinical atherosclerosis. Extensive investigation has demonstrated that the limitation of cholesterol alone would not depress the blood cholesterol level without the concomitant limitation of dietary fat. With the realization of the importance of endogenous cholesterol formation it seemed clear that the fat content of the diet was the important factor if cholesterol or other blood lipids are to be reduced. Serious doubts have been expressed, however, because acetate is available in adequate quantity even in the low-fat diet to permit endogenous cholesterol production to continue. It has recently been suggested that a negative caloric balance is an even more important factor. An excellent study of subjects with normal and elevated blood cholesterol levels has shown that levels can be lowered in both groups on low calorie diets containing appreciable quantities of both cholesterol and fat.

Cholesterol—Phospholipid Ratio

The ratio of cholesterol and phospholipid received attention when it was noted that increasing the phospholipid content of the blood in experimental animals prevented the production of the lesions of experimental atherosclerosis. On the basis of the evidence at hand it seems entirely possible that this ratio is an important one for the maintenance of plasma colloid relationships and a lowering of the phospholipid or elevation of the cholesterol increases the ability of cholesterol to become available to the arterial wall. The use of so-called plasma stabilizers such as choline and lecithin, however, has not been shown to alter the course of atherosclerosis in humans as yet.

The fractionation of proteins by the Cohn method of electrophoresis has shown that the blood cholesterol is joined with alpha, and beta globulins to form alpha and beta lipoproteins. It has further been shown that about 25% of the cholesterol is contained in alpha lipoproteins and the remaining 75% in the beta lipoproteins. Barr and associates demonstrated that the beta lipoprotein is consistently increased at the expense of the alpha lipoprotein in clinical atherosclerosis and in diseases characterized by high levels of blood cholesterol. It was suggested that this increase might contribute to a tendency to instability of lipid emulsions in plasma and tissue fluids.

Ultra-centrifugation of the serum lipids by Gofman and associates led to the discovery that the lipoproteins could be made to undergo flotation in saline at certain rates of speed depending on the optical density of the molecular aggregate. By this rather complex technical method, it was found that the lipoproteins could be divided according to density along a scale from the largest molecular aggregate, Sf 40,000 and above down to Sf 4. The upper limit of 40,000 represents the class of lipoproteins called chylomicrons. Evidence has been produced to show that this range of values from Sf 40,000 down to Sf 4 represents a metabolic chain down which the lipids are degraded until they reach the lowest density of Sf 4 at which point they represent fatty acids and glycerol esters and after which they disappear by final utilization. Evidence was also produced showing that most, if not all, of the cholesterol was represented in the Sf 12-20 range. The elevation of the Sf 12-20 range was shown to correlate better with clinical evidence of the atherosclerotic state than blood cholesterol levels. Alterations of the Sf 12-20 lipoproteins toward normal were produced more readily by the use of dietary restriction of cholesterol and fat than were cholesterol levels indicating a more sensitive or perhaps more direct relationship of the lipoprotein molecules to the process of atherogenesis than cholesterol itself shows.

A sense of controversy seems to have been generated by the proponents of each of these theories concerning the role of blood lipids, but more recent studies indicate that general agreement has been reached that they are merely facets of the

same basic difficulty—a deranged lipid metabolism. The view is now held that the different mechanisms may play a predominant role under different circumstances.

Most recent studies of clinical atherosclerosis combine the use of all of these four types of observations to form what are termed the plasma lipid patterns. An example of the usefulness of combining these different approaches to the problem is the recent work of Barr and associates at Cornell.

Comparison of Lipid Patterns

Stimulated by the observation that man is the only mammal showing spontaneous atherosclerosis to any degree, Barr has compared the lipid patterns in the normal rat, dog, and rabbit with normal human babies, normal young men and women, normal older men and women, human patients suffering from diseases known to predispose to extensive atherosclerosis, and human subjects with proved coronary atherosclerosis. It was noted that newborn babies showed lipid patterns most like the immune mammals. Sometime during childhood, probably quite early, those characteristics are lost and the normal adult values for total cholesterol, cholesterol-phospholipid ratio, cholesterol contained in the alpha and beta lipoproteins, and Sf 12-20 lipoproteins are attained. Older individuals tend to show slight changes toward the abnormal patterns seen in patients with diseases which predispose to atherosclerosis, whose patterns in turn resemble those of patients with myocardial infarction. Thus, there is a rise in total cholesterol not accompanied by a rise in phospholipid and hence an increase C-P ratio. There is an increased percentage of cholesterol in the beta lipoproteins and a rise in the Sf 12-20 lipoproteins.

It was further noted that premenopausal women most closely resemble newborn babies and immune mammals in the lipid patterns and this correlated well with the relative freedom of premenopausal women from coronary heart disease.

Influence of Estrogen

The most obvious difference between premenopausal women and the other adults is the presence of circulating estrogen, and attention was focused on the therapeutic implication. As subjects for a test of the idea, men who had survived myocardial infarctions were selected and treated with Premarin or Estinyl in amounts sufficient to produce changes in size of breasts and a temporary loss of sexual potency. The response in the abnormal lipid patterns was striking and uniform. In every instance there was an increase in the percentage of cholesterol in alpha lipoprotein and a corresponding decrease in the percentage of cholesterol in the beta lipoprotein. There was a marked fall in the cholesterol-phospholipid ratio and in most cases a fall in concentration of total cholesterol in the plasma. The values finally obtained were approximately those of healthy young men. When the medication was discontinued, the concentration and distribution of lipids promptly returned to their previous levels. It was noted that the simultaneous administration of testosterone blocked the effect only to have it reappear when testosterone was discontinued. This action of testosterone suggests that it might not be a desirable medication in patients with extensive atherosclerotic disease since deviant patterns were produced in those who were previously normal.

This would appear to be a most significant advance in our understanding of the genesis of atherosclerosis. Even though the clinical usefulness of estrogen remains to be shown, the fact that lipid patterns can be manipulated readily represents an important step in this field where answers to most of the fundamental questions are lacking. It may be expected that more rational therapeutic measures will result from studies now in progress than have been available in the past

The Diagnosis of Bacterial Endocarditis*

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In spite of new technics of therapy of bacterial endocarditis, the diagnosis of this disease continues to be an important problem. Nowadays it is seen much more commonly by most physicians than is cardiovascular syphilis. Bacterial endocarditis has been the cause of death in about ten per cent of all patients afflicted with rheumatic heart disease[1] and its incidence varies with the incidence of rheumatic valvular disease. Dowling and Murray[2] found a total incidence of bacterial endocarditis of 2.4 per 100,000 in Washington, D. C. hospitals in 1948. If this figure is representative, there were 3400 cases and 2000 deaths in the U. S. in 1948 due to this disease. The penicillin alone cost about half a million dollars.

Bacterial endocarditis has been subdivided into acute and subacute types.[3] Acute bacterial endocarditis[4] is typically caused by a virulent pyogenic organism in the presence of a grossly apparent focus, may involve previously normal valves, and ends fatally in less than six weeks if untreated. Subacute cases are caused by non-hemolytic streptococci in about 95 per cent of cases,[3] almost invariably involve patients with congenital or rheumatic heart disease and may last several weeks or months. Such a classification of the disease into two varieties is often difficult, particularly now that antibiotic therapy has profoundly altered the duration of the illness, and is largely academic. It is preferable to designate cases by the infecting organism, i.e., streptococcic viridans endocarditis, enterococcic endocarditis, etc.

We propose to review the pertinent literature and present the significant data concerning 49 cases of bacterial endocarditis admitted to the University of Illinois Research and Educational Hospitals. All 49 cases were proved by positive blood cultures in the presence of a clinical picture consistent with the disease, by necropsy, or by both, and all received penicillin for 48 hours or more. Five of these cases have been previously presented in detail.[5]

In our cases, the mean duration of delay from onset of symptoms until the beginning of final definitive treatment was 4.8 months, with a range of two days to two years. 42.8 per cent of the patients had been treated with antibiotics prior to admission, in several instances under an incorrect diagnosis. The usual slight male preponderance (28 of 49) was found in this series. There is no significant racial predilection. Ages ranged from nine to 65 years. The rarity of bacterial endocarditis in infancy has been stressed repeatedly and holds true for patients with congenital malformations of the heart, although they may show an appreciable incidence of such infection later in life.[6,7,8]

Associated Heart Disease

In seven of our 49 cases the infection was associated with congenital heart disease; one case had syphilitic heart disease; one a previously normal heart, while the remaining 40 cases had rheumatic valvular disease. Necropsy examination in 20 cases (some of whom died long after cure of the infection and of unrelated causes) revealed the following sites of localization of the infection: two on a patent ductus arteriosus; one tricuspid valve in a previously normal heart; one supraaortic stenosis of a rare type; one syphilitic aortic valve; one Tetralogy of Fallot; five rheumatic aortic valve; three mitral valve; and six combined aortic and mitral. Bacterial involvement of the mitral valve was suspected clinically in 19 of the 40 cases with pre-existing rheumatic heart disease, while the aortic valve was thought to be the site of vegetations in 10 and both valves in 11. The rarity of finding bacterial endocarditis as a complication of syphilitic aortic valve disease or interatrial septal defect is well recognized.[3]

Symptoms

The early symptoms of bacterial endocarditis are commonly only those associated with fever and labeled "flu" or "grippe" by the patient. These may be the sole complaint for several weeks. Other patients may present themselves because of complicating factors such as congestive failure or peripheral or pulmonary emboli.[3,7,12,16] Occasionally other causes for fever are found and further

*The cases presented were studied in the Department of Medicine, University of Illinois College of Medicine, Chicago.

search abandoned. Three cases in this series had an associated active pulmonary tuberculosis and another untreated case had Hodgkin's Disease and myocardial infarction at necropsy.

Precipitating factors [3,7,9,12] should always be searched for although in the majority of cases they will remain unknown, as was true in 6 of our cases. Dental procedures preceded the onset in at least nine, upper respiratory infections in eight, criminal abortions in three (all with enterococcic infection), "pneumonia" in two, and a probable urinary infection in one.

Physical Findings

The importance of suspecting bacterial endocarditis in any patient with a cardiac murmur and persistent fever has been emphasized for decades. These two findings are present in nearly all cases but occasionally fever is absent[10] or rectal temperatures are necessary to demonstrate it, particularly if the patient has been recently and inadequately treated. Table 1 lists the frequency with which abnormal physical findings have been noted.

One of our patients developed the unusual complication of a ruptured spleen one week after admission and survived following splenectomy and large doses of antibiotics.[14] Atrial fibrillation, relatively uncommon in this disease,[3,7,9,15] was present in only four of our 49 cases and in two of these it developed after admission. Sometimes a prolonged PR interval appears on electrocardiograms adding to the difficulty of ruling out active rheumatic fever. Except for the dramatic examples of rupture of valve cusps or chordae, a change in the quality or intensity of heart murmurs is probably overemphasized as a diagnostic sign, since such changes occur in other illnesses, due to variations in the degree of fever, tachycardia and anemia. On the other hand, persistent systolic or diastolic murmurs during the course of the illness may lead one to an erroneous diagnosis of the type of underlying rheumatic valvular disease present.[12] Mitral stenosis, for example, tends to be overdiagnosed.

Routine blood counts and urinalyses are often abnormal but rarely helpful in establishing a specific diagnosis. Hematuria is a valuable clue but it is absent in about half the cases. Anemia occurs in the great majority of cases and may be profound.[10] Occasionally, competent physicians will dismiss the diagnosis of the bacterial endocarditis because of a normal leucocyte count, yet nearly all reported series of cases reveal that leucocytosis is frequently absent. Some of the reported laboratory findings are listed in Table 2.

Blood Cultures

The sine qua non of diagnosis is a positive blood culture. Because of the frequently rapid deterioration of the cardiac, renal, or cerebral status of these patients,[17,18] it is suggested that six blood cultures be taken at hourly intervals. The custom of obtaining one culture every 24 hours only seems to delay treatment and has never been proven to yield a higher percentage of positive results. The most interesting feature of our series was the frequency with which positive cultures were obtained on the initial venepuncture. In seven cases no organisms were ever isolated antemortem in spite of 12 to 51

Table 1

PHYSICAL SIGNS

Author	Thayer[11]	Kelson & White[12]	Seabury[13]	Paul[9] et. al.	Parsons[10] et. al.	Hall
No. cases	78	250	165	44	200	49
Murmur	.....99-100% in all series					
Emboli incl. petechiae	67%	86.5%	57.7%	34%	61%	49%
Palpable Spleen	44%	59%	46.6%	41%	44%	53%
Clubbed Fingers	44%	46.7%	37.4%	23%	17%	25%
Fever		100%	99.4%	90-100%	75%	100%

Table 2

ROUTINE LABORATORY FINDINGS

Author	Thayer[11]	Kelson & White[12]	Seabury[13]	Paul[9] et. al.	Parsons[10] et. al.	Hall
Hematuria	47%	49%	40.7%			57%
WBC over 10,000	72%		43.5%	55%		39%
Hgb under 12 G. or RBC under 4 M.			70%	68%	75%	75%

blood cultures from each. Four patients revealed positive results on the second, third, and fifth cultures respectively. The remaining 3 cases had positive cultures on the initial venepunctures. Thus all positive cultures were obtained within the first five attempts and 90.5% of these were positive on the first attempt. Somewhat similar results in a group of 83 patients were obtained by Cates and Christie.[7]

Bacteria involved in our 49 cases were the alpha streptococcus (viridans) in 30, unknown in seven, enterococcus in five, staphylococcus in four and gamma streptococci in three. Staphylococcic endocarditis is more prone to occur without preexisting cardiac disease, to follow unsterile intravenous injections (drug addicts) or abscesses in the skin or elsewhere, and to be accompanied by chills, meningismus and a high leucocyte count. More of these cases are being reported in recent years, while the pneumococcic and gonococcic varieties are seen less frequently.[4,11] Enterococcic endocarditis may follow genito-urinary or rectal surgery or septic abortions. A great many species of bacteria and fungi have been responsible for cases of bacterial endocarditis, and in the individual case it is usually impossible to predict the causative organism on clinical grounds alone. It should be recalled that infections confined to the right side of the heart and pulmonary artery are more likely to develop pulmonary infarcts, and less likely to furnish positive blood cultures than are cases with vegetations on the mitral or aortic valves.[19]

Often the chief problem in differential diagnosis[12] involves active rheumatic fever since fever, heart murmurs, congestive failure, systemic or pulmonary emboli, splenomegaly, arthralgia, anemia, albuminuria, leucocytosis, and electrocardiographic abnormalities may occur in either disease. A history of chills, recent tooth extractions and the finding of petechiae and hematuria in a patient over 16 years of age strongly favor bacterial endocarditis, while subcutaneous nodules, erythema marginata, frank arthritis and chorea point to rheumatic fever. Occasionally the two diseases co-exist.

Therapy

If bacterial endocarditis seems clinically probable in a patient with persistent fever of over one week in duration, it seems wisest to start antibiotic therapy after six blood cultures have been obtained at hourly intervals. Adjustments in dosage and in choice of drugs may be made after identification and sensitivity tests have been completed. If no growth occurs in cultures and the clinical evidence for the diagnosis remains good, a massive treatment regimen should be instituted since cases from whom positive cultures are never obtained have a much higher mortality than those from whom an organism is identified.[7,17,18] Such a program of early diagnosis and early therapy offers the best hope of improving the long term survival rate of large series of patients with bacterial endocarditis which has been fixed at around 70% for the last several years. Too many cases are allowed to reach a stage of irreversible congestive failure, uremia or cerebral damage and die even though a bacteriological cure has been effected.

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Injuries of the Liver

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The liver is the largest and the most frequently injured of the solid abdominal organs. Despite the fact that it has as a shield the lower portion of the costal cage, it is vulnerable to various types of injuries, because of its relatively fixed position and its friability.

Severe liver injuries have always carried a high mortality rate—generally considered to be about 60%—as compared with other abdominal injuries. The addition of other visceral trauma to that of injury to liver increases the mortality rate much above the individual sum of two isolated injuries. During the past 15 years there has been a progressive decrease in mortality in all types of abdominal injuries, especially as related to trauma of the liver. Credit for this improvement must be given to the following factors:

1. The availability of whole blood, plasma, and substitutes.
2. The improvement in anesthesia.
3. The improvement of surgical techniques.
4. The antibiotics.
5. The experience gained during World War II in the management of these injuries.

When the continuity of the liver is disrupted there is always hemorrhage. This bleeding is free, continual, and copious. The hemorrhage is more venous than arterial, since the liver receives approximately 60% of its blood supply from the portal system. Therefore the most common cause of death from injuries of the liver is shock secondary to hemorrhage. The extent of injury, the combination of injury to other abdominal viscera, rapid transportation, early institution of antishock therapy, and well planned surgical exploration are all factors that determine the survival rate.

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Symptoms and Classification

Characteristic symptoms that are associated with rupture of the liver are those of immediate pain in the right upper quadrant. The pain most often is constant, and is exaggerated by deep breathing or moving about. There may be radiation of pain into the right shoulder (Kehrer's Sign). Vomiting is frequent and may be followed by retching. Shock and collapse are almost immediate if the liver is severely torn. Shock may be delayed for a period of hours if the bleeding is slow but progressive.

With a large amount of bleeding into the peritoneal cavity there is usually abdominal distention with doughy sensation to palpation. The distention is the result of ileus plus displacement of loops of the intestine anteriorly by free-lying blood. Percussion will reveal shifting dullness in the flanks, and generally large

quantities of free blood in the peritoneal cavity will cause some peritoneal irritation with rebound tenderness. Signs of shock become progressive when hemorrhage has been steady. In some situations it is advisable to aspirate the abdominal cavity, remembering that a negative aspiration does not rule out intra-abdominal hemorrhage, but that false positive results are uncommon. There is very slight risk if a small gauge needle is used. This test has been estimated to be approximately 85% accurate in establishing a diagnosis of intra-abdominal hemorrhage. Muscular guarding and localized tenderness are nearly always present in the upper quadrant. Examination of the blood count and hemoglobin may be helpful, but during the first few hours there may be little change. Flat and upright films of the abdomen are not of value except to rule out other associated intra-abdominal injuries, such as perforated hollow viscus.

Injuries of the liver can be classified as follows:

1. Non-penetrating
2. Penetrating
3. Operative

Injuries that result from non-penetrating wounds are frequently referred to as subcutaneous injuries. These result from compressive or crushing forces, heavy blunt blows from kicks, fists, rocks, sticks, falls, or from blast concussion. Often this type of trauma is underestimated. Symptoms are then attributed to contusion or hemorrhage in the anterior abdominal wall, or to fractures of the ribs. This is especially confusing if injuries of the liver result in a subcapsular hematoma or in delayed bleeding. There is a tendency to discharge such a patient from the hospital after a short period of observation, with the result that several weeks afterwards a relapse with signs of intra-abdominal hemorrhage may occur.

Management

The management of non-penetrating wounds following abdominal trauma taxes the ability and judgement of a surgeon more than do injuries associated with penetrating wounds. Errors are made more often on the side of omission than on the side of commission. The physician too often observes the injured patient who does not have an open abdominal wound beyond the period of safety. Inadequate preoperative planning results from the attempt to save the risk of operation, and one is placed in the unhappy situation of having to do hasty and inadequate surgical exploration upon an extremely poor risk patient. The most difficult of the problems presented is that of the severely injured patient in shock with evidence of a non-penetrating abdominal injury, who has other severe injuries, such as head injury, compound or multiple fractures, chest injury, or severe laceration. Any one of these injuries could be responsible for the state of shock.

Penetration of the liver results from knife or gunshot wounds, and various other instruments and missiles. The location and direction of the wound give the surgeon a clue as to the damaged viscera before the abdomen is opened. Knife wounds are usually small and cause the least amount of damage. However, knife wounds should be explored rather than probed to determine the direction and depth of the wound, since the physician will often get a false sense of security if his probe does not follow the path of the first instrument. Small calibre, low velocity bullets will generally cause punched out wounds, whereas larger calibre, high velocity missiles may cause fracturing of the liver with deep and long fissuring, and a surrounding area of non-viability about the tract due to concussion.

Wounds of the liver may be in an inaccessible portion of the liver, or they may be so massive that large portions of the liver may be destroyed. It may be necessary to extend an abdominal approach into a combined thoraco-abdominal. The thoracic approach is advisable if the injury is to the superior portion of the liver alone, or is combined with a chest wound but not involving other abdominal viscera. Often metallic fragments that are buried deep within the substance of the liver will be difficult to remove and are better left in place rather than attempting to dig them from the liver. The following case report represents a rather unusual type of penetrating and perforating wound of the liver, resulting from an industrial injury:

Mr. L. W. P., age 26, was injured 5 December, 1952, while operating a shear machine. A broken, loose metallic fragment from the punch was ejected and struck the patient in the epigastrium. Pain was severe, and he collapsed immediately. He was transported to the hospital in a short period of time.

When seen in the receiving room he was a very apprehensive, pale, young male adult, complaining of extreme upper abdominal pain. His abdomen was rigid and generally tender with generalized rebound pain. There was an irregular wound of entrance approximately 3 cm. below and 4 cm. to the left of the xiphoid process. The wound was approximately 3 cm. in length; there was very little external bleeding. There was no wound of exit. Chest examination was normal.

He was taken directly to the operating room where he was placed on the table in Trendelenburg's position, and oxygen was given together with intravenous glucose and morphine. Response to treatment was prompt with blood pressure reading in a few minutes at 110/84 and with a full pulse of good quality. General anesthesia was given, and the abdomen was opened through an upper transverse incision, dividing both recti. The peritoneal cavity contained a moderate amount of free blood and several large clots which were removed. There was a wound approximately 2½ cm. in length on the anterior surface of the left lobe of the liver, 2 cm. lateral to the falciform ligament. Bleeding was slight. Palpation revealed a metallic object projecting about ½ cm. above the surface of the liver on the extreme lateral and superior surface of the right lobe, which was difficult to visualize. The metallic fragment was extracted without any further damage to the liver. Bleeding from the wound of exit was brisk after removal of the foreign body, but was controlled by packing with an abdominal pad.

The metallic foreign body was long and slender and shaped in the manner of the letter "J". The straight length was 6 cm., and the curved portion 2½ cm. in width. The shaft was triangular with quite sharp edges; cross section of the shaft was about ½ cm.

The hepatic wounds of entrance and exit were packed with gelfoam sponge. No other intra-abdominal injuries were found. The diaphragm was intact. Drains were placed in the right suprahepatic and infrahepatic spaces and brought out through a stab wound in the right flank. Drains were placed also in the left suprahepatic space and were brought out through the wound of entrance in the anterior abdominal wall. Closure of the abdominal wall was in layers, using interrupted silk sutures.

Postoperative treatment consisted of several days gastric decompression with intravenous feedings, Vitamin K, penicillin, and demerol. Recovery was uneventful except for a small pulmonary infarct in the left lower lobe on his 10th postoperative day, which prolonged his hospital stay by about 5 days. A temperature curve showed daily elevations between 99° - 100.8° for the first 14 days. Drainage was moderate, changing from sanguineous to bile stain. The drains were completely removed on the 14th postoperative day. He was discharged from the hospital on his 18th postoperative day, and returned to work 4 weeks later. One year follow-up showed him to be in good health without any residual difficulties from this injury.

Complications

Operative injuries generally are small and are more troublesome than serious. Many of them are brought on by rough handling and improper use of retractors to displace the liver. The most tragic of operative injuries result from damage to the right hepatic artery by careless or inaccurate occlusion and ligature with the cystic artery during biliary surgery. This frequently produces later necrosis of the greater portion of the right lobe with subsequent liver failure and death.

The complications that are associated with injuries of the liver are:

1. Prolonged convalescence
2. Infection and delayed hemorrhage
3. Biliary peritonitis, fistula, or empyema
4. Pulmonary complications
5. Hepatic failure
6. Wound disruption
7. Hepato-renal syndrome

Discussion

In general the treatment of injuries of the liver is surgical. Conservative treatment has little place in the management of these injuries. The pre-operative care should be directed toward making the patient comfortable and correcting the physiological changes. Shock should be treated, but if it is reasonably sure that bleeding is active and rapid, too much time should not be spent in this phase of the treatment. The patient should be taken to the operating room and either arterial or intravenous transfusion should be started. Generally it might be said that

the mode of hemorrhage from liver wounds is primarily venous. Frequently bleeding will have ceased secondary to the drop in blood pressure before surgical exploration is started, or, if continuing, can be controlled by temporary packing. The primary purpose of surgical management is that of control of hemorrhage; secondary purposes are removal of any necrotic, non-viable, or free detached liver fragments that are found lying in the peritoneum, and the establishment of adequate drainage. Loose fragments of non-viable liver tissue in the peritoneal cavity act as foreign protein matter and produce a severe toxicity.

Hemostasis can be accomplished in the following manner:

1. Some lacerations that are not too extensive or irregular may be sutured. If the laceration is in the free margin of the liver, even though it may be of small extent, is should be sutured or have parallel mattress sutures placed along the free margin for hemostasis. There is a tendency for this type of laceration to gape and be held apart, with little tendency to seal off with either blood clot or omental plug, because it lies on a narrow, free hanging edge.

2. Bleeding may be controlled by packing with crushed muscle or an absorbable material such as gelfoam or oxycel gauze. Sometimes it is necessary to use temporary gauze packing. Gauze packing should never be utilized as the final method of controlling hemorrhage, because there is a great tendency for hepatic sepsis to occur about foreign materials. Often there will be profuse secondary hemorrhage in attempting to remove gauze packing. Removal of packing from the liver is a painful procedure and must be done under general anesthesia.

3. In extensive or massive injuries in which there may be pulping of the liver substance, with portions of the liver deprived of blood supply, it may be necessary to resect that portion of the liver. The liver can be resected without too great a loss of blood by first placing through and through heavy catgut mattress sutures parallel to the line of incision and controlling the bleeding as the liver is incised. Compression of the liver substance manually may control bleeding during incision. After incision fine ligatures are used on individual vessels and bile ducts on the cut surface of the liver. The raw surface is covered with oxycel or gelfoam gauze, loosely approximating the liver over this substance. If the bleeding is too copious during the procedure, it can be controlled temporarily by placing the index finger in the foramen of Winslow and compressing the arterial and portal blood supply to the liver.

No matter which means is used to control bleeding, drainage is always necessary. Following disruption of the liver there will be biliary drainage which produces severe chemical irritation. In small quantities it causes more pain and discomfort than serious complications. In large quantities it may cause peritonitis with shock and death. It is usually necessary to leave drains in place for several weeks or months, or until bile drainage has subsided. In instances in which there is a combination of wound of the chest and abdomen, involving liver, associated with a tear in the diaphragm, drainage should be applied not only to the area of injury to the liver, but also suction drainage in the pleural cavity should be used because of the frequency of bile empyema. The rent in the diaphragm should be sutured tightly. Drains are then brought out from below the diaphragm. These drains are never brought out through the wound in the diaphragm, because of the probability of biliary empyema following this path of drainage.

The most important point to be made in the management of these injuries is that if injury of the liver is suspected, exploration is more conservative than observation. The mortality rate of early exploration is much lower than when treatment is delayed, and the end results are better.

Summary

1. The treatment of injuries of the liver is surgical.

2. The mortality rate has decreased in these injuries over the past 10 or 15 years due to multiple factors.

3. The goal of surgery is to stop hemorrhage, remove devitalized liver tissue, and then establish adequate drainage.

4. A case of perforating injury of the liver has been presented.

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First Aid and Early Care*

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"First aid[1] is the immediate and temporary care given the victim of an accident or sudden illness until the services of a physician can be obtained. It may mean the difference between life and death, between rapid recovery and long hospitalization, between temporary disability and permanent injury." A physician is present infrequently to render first aid, but he may be and he needs to know the fundamentals as well as the trained layman. He should be competent to advise on the preparation of first aid manuals or to instruct first aid classes, if requested. Further, he must have enough knowledge not to criticize adequate first aid if he has nothing better to offer. There are many first aid manuals of varying value, but the American Red Cross First Aid Textbook is probably the most complete, safe and frequently revised. Interns, residents and the general profession should know its content.

Immediate Considerations

Keep an open airway.

All wounds are contaminated. Prevent further contamination by covering with a sterile dressing. Don't use antiseptics. If a period of several hours must elapse before definitive treatment can be given and soap and running water are available the wound may be washed with these before applying a sterile dressing, except in the case of burns.

External bleeding can almost always be stopped with a pressure dressing. Pressure points are not worth considering. Never use a tourniquet unless absolutely forced to as there are undoubtedly more deaths and loss of limbs from the use of a tourniquet than from failing to use one. But you should know how to apply one properly.

If the injured person is found unconscious and has alcohol on his breath, consider that he has a brain injury until proved otherwise. Keep him lying on his side so that his tongue does not fall back and he does not drown in his own secretions.

Splint fractures.

Speed of transportation to a hospital is not the important criterion, but care that all moving is done without further damage to the patient. Lives are lost by speed without care.

In this section we can only outline basic principles to prepare the injured person for definitive care in an operating room. This will not include the care of fractures, which is considered elsewhere[2], except as this occurs as a part of the multiple injuries. Let us presume that a seriously injured person or one with multiple injuries is presented to us.

Asphyxia, Shock and Hemorrhage

The care of asphyxia, shock and hemorrhage, if they exist, take precedence over everything else. If the patient is cyanotic or breathing with difficulty, we must make certain that he has an open airway, not filled with blood and mucus. Blood transfusion will do little good if the lungs are physically prevented by obstruction from receiving the oxygen to aerate the blood. Brain centers will not function long if aerated blood is not reaching them. If the pharynx and trachea continue to fill with blood and fluid in spite of suction, tracheotomy may be the conservative procedure. A catheter inserted through a tracheotomy tube is frequently a more comfortable and less traumatizing procedure than a metal suction tip rammed against the back of the pharynx or the epiglottis. It also assures an open airway, unless the bleeding is beyond the main bronchi.

If not in shock, the patient probably will be in a short time. Do not wait for the blood pressure to fall before instituting shock treatment as this is a sign that shock is already far advanced. Give morphine to relieve pain, except in brain injuries, and give enough to relieve it. Often absorption is poor and the dose may better be given intravenously. But don't give morphine, except as indicated for pain. If he is cold, warm him up and keep him warm, but this does not mean piling on hot water bags and blankets until he is bathed in sweat. If he is losing precious fluid and

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needs a transfusion, obtain the blood and cross match at the earliest moment, but have plasma extenders running in the meantime. This will help prevent or relieve shock and will not waste time getting a needle into a vein when blood is ready. Remember whole blood is the fluid really needed in traumatic shock, except possibly from burns, whether there has been evidence of loss of blood or not. Administration of too much fluid can be as dangerous as too little. Frequent checking of the specific gravity of the blood or the hematocrit is needed to furnish the right amount. Blood volume is the all important test, but is hardly generally practical as yet.

Hemorrhage must be stopped. Proper pressure application is almost always sufficient for external bleeding. Preventing further bleeding is nearly as important as replacing the blood lost already. Symptoms of hemorrhage without external evidence of it may require the finest in surgical diagnosis and judgment.

Physical Examination

Shock and hemorrhage must be considered first. Further treatment cannot be rendered except on a live patient. Next and accompanying it as far as possible is the physical examination. The method of examining the extensively injured is of great importance to him. It must be gentle and without undue exposure in order not to increase shock. Which are the immediately important fractures? Is there a possible abdominal or chest injury? With signs of possible abdominal injury we must consider the solid organs, liver and spleen, the hollow viscera with possible perforation, the blood vessels, e.g., mesenteric, the retroperitoneal organs—kidney, adrenals, retroperitoneal hematoma, spine and spinal cord, perforation of the diaphragm, etc. We must decide whether any operative procedure is indicated to be done at the first possible moment, which part of the body will be approached first when the condition improves sufficiently to do anything, whether no marked improvement can be expected in the general condition until some intervention has been accomplished even if the person dies in the attempt. These decisions may need to be changed as the condition changes, but we must constantly keep in mind doing first things first. There is no use applying skeletal traction for a fractured femur and spending time carefully arranging traction suspension when we believe the abdomen must be explored at the earliest possible moment, requiring the taking down again of the traction apparatus. Rather keep the part in emergency traction until decision is made regarding the abdominal trauma.

X-ray Examination

X-ray examination is often carried to a ridiculous extent. What films do you absolutely need to determine what you will do to the patient first when possible and what will prevent further injury in the meantime? Demonstration of free air below the diaphragm may prove rupture of a hollow viscus. Examination for this is of little use unless the patient is in the upright position. The presence of a vertebral column injury may need to be proved before the patient can be supported in the sitting position without danger of spinal cord damage. However, the use of a tilt table allows the examination for free air without endangering the spinal cord.

Too many early x-rays of the skull are taken. Unless the patient is co-operative enough to keep his head quiet, these should be postponed unless one believes it is absolutely necessary to determine the presence of an open depressed fracture or a fracture at a site which could readily produce an injury to the middle meningeal artery. Otherwise no operative intervention on the skull is going to be instituted early anyway and x-rays for the record may be done better later.

The presence of fractured ribs proved by x-ray will usually make little difference in early operative treatment. There may have to be treatment for pain on breathing, for tamponade of the lungs with blood, for paradoxical respiration or tension pneumothorax, but time and effort spent on x-ray of the chest offer little in the early care of the extensively injured that cannot be learned equally well or better by the physical examination. Anesthetizing the proper intercostal nerves may often change the picture entirely in a patient suffering severe chest pain. The blood must be kept oxygenated; adhesive strapping to the chest interferes with this.

Beds in the admission ward are a practical necessity in these cases. Close supervision is necessary. Many patients suffer further injury and exposure in nonmedically supervised movement from stretcher to x-ray table, ward bed or operating table. For an orderly to undress a patient

behind a screen often constitutes an acute danger. It is better to cut off a good shoe than to make a closed fracture of the leg open in attempts to pull it off. Coats and pants are much better cut for removal if movement might in any way endanger the patient. Critical time is lost in moving to a ward, etc., which should be employed in getting plasma extenders and blood into a vein. Do not be satisfied with ordering fluids but know that they are commenced immediately.

Wounds should be cleansed, excised if indicated, and sutured as early as practical. Much loss of time and possible infection will be saved to the patient if he gets well, but this work must not endanger his life further by increasing shock or taking an assistant from more necessary procedures.

Hemorrhage must be stopped and an open chest wound closed immediately. Evidence of intra-abdominal perforation calls for operation as soon as the general condition is improved sufficiently to stand it. Otherwise there are few conditions that require operation until recovery from shock seems quite definite.

Prevention of Tetanus

Protection against tetanus is required in most contaminated wounds. Give 1500 units of tetanus antitoxin, except that if a person has been in the Armed Forces since the beginning World War II he should be given 1 cc. of tetanus toxoid for any open injury, not antitoxin. It is safe to assume that he had his original injections and his booster dose after one year. It is considered that for at least ten years thereafter any injury requires only another booster dose. Urge all veterans you come in contact with to have a booster dose now. Severe reactions to tetanus antitoxin are common, so toxoid should be used when the person has been previously immunized with toxoid. Many children have had tetanus toxoid but they or their mothers rarely know with certainty whether this is true.

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Medical Treatment of Portal Cirrhosis

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Because of the restrictions of time, my remarks will be confined to a discussion of the medical treatment of portal cirrhosis. There has always been a lively interest in the liver. Primitive people long recognized its importance to their well being.

"The practice of divination by hepatoscopy far antedated the Phoenicians. It was a typical Babylonian art. The baked clay models of livers marked off in squares can still be seen in museums. The practitioners of this cult spread far and wide from Mesopotamia, perhaps even into the northern forest and plains before the breakup of the Indo-European peoples. The Babylonia term for liver was *Khabittu.*"[1a]

"Hepar was replaced by *Ficatum* (fed on figs) which gave the French *Foie* and the Italian *Fegato.* Evidently the goose liver with fatty infiltration was a delicacy even in those days of early language formation."[1b]

Periodically, this interest has been stimulated or rekindled by the stress of war-induced epidemics of liver disease and new physiological and pharmacological concepts. Since World War II there has been a great increase in the application of certain direct and indirect diagnostic methods. Investigations have clarified the role of the liver in fat transport, desaturation, and methylation and have emphasized its importance in protein synthesis and breakdown. Experimentally, the relationship between liver metabolism and accessory food substances has been clarified with resultant extensive clinical application. Thus, these things have led to a greater awareness of liver disease, its causation, pathophysiology, and possibly to better treatment with prevention of *Ascites Nosos* (the baggy disease). Among the many published papers on this vast subject, those of Robert M. Kark[2] and Sidney A. Portis[3] are notable.

The incidence of clinical cirrhosis of the liver is not exactly known, but it is generally conceded to be rising. From au-

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topsy material it is stated to be 6%[4]. A much higher incidence of so called latent or incidental cirrhosis exists. There is one recent figure of 21% given as the incidence for latent cirrhosis[5]. From our own experience I would guess that approximately 10% of the patients that I see show evidence of liver disease and most of these probably have so called latent cirrhosis. On many such patients liver biopsies have been done confirming the diagnosis. The incidence of cirrhosis of the liver is higher dependent upon the particular doctor's interest in liver disease, his diagnostic acumen and the laboratory tests that are available, including needle biopsy of the liver. I do not feel that cirrhosis of the liver is peculiar to any region, sex or race. It may be related to some occupations since a very high incidence of cirrhosis is found in those who handle alcohol in one way or another.

Etiology

By definition cirrhosis is supposedly a progressive chronic disease of the liver which indicates that an agent or agents are still active for the pathogenesis of this disease. It is now well known that the liver reacts much the same to a wide variety of agents whose action however may be limited. Lesser degrees of injury may be followed by fairly normal restitution of structure and function and thus in a sense the disease is reversible. The present trend is toward the concept that cirrhosis is a disease due to a primary injury which interferes with cellular metabolism such as a nutritional deficiency or even a mild virus disease and that secondary factors may play a very great role also. The best known secondary offender is alcohol[6]. Approximately 80% of all patients that I have seen with verified portal cirrhosis give positive histories for the use of alcohol and in most of them the intake would be considered rather great. Despite the immense amount of work and innumerable papers written about the patho-physiology in liver disease it is still not clear as to the "why" of ascites or of the vascular shunts in and about the liver or what constitutes liver failure—so called cholemia.

In the literature are seen the terms compensated and decompensated with reference to the clinical aspects of cirrhosis which is another way of saying some patients are living with their disease, other patients are dying with it. These are purely arbitrary terms and have to do with the symptoms and signs of advanced cirrhosis of the liver with reference to portal hypertension, impaired excretion of the liver and parenchymatous failure on the part of the liver. The ultimate good prognosis of any patient with cirrhosis of the liver depends upon his ability to overcome these three aspects of cirrhosis.

With the present poor concept of pathophysiology, treatment of cirrhosis of the liver is of necessity empirical. It should be clear that in any disease the elimination of the cause of that disease state should be the primary purpose. In the United States, cirrhosis of the liver most commonly is found in those patients with a history of malnutrition and heavy alcohol ingestion. These patients spend millions of dollars for alcohol and usually wind up owing for their medical care. Cirrhosis is not confined to any economic segment of the population. Our statistics point to a marked increase of cirrhosis of the liver since repeal of the Volstead Act. Research publication number 35 by the Commonwealth of Kentucky on alcoholism, dated 1953, should be read by all doctors of Kentucky[7]. Alcoholics are seven times more numerous than tuberculosis cases. A conservative estimate places the number of alcoholics in the United States at almost 4,000,000. Nearly 1,000,000 of this number have suffered physical and mental deterioration caused by their excessive drinking. In Kentucky it has been estimated that there has been a 27% increase in alcoholism compared to 1940. In 1940 it was estimated that alcoholism cost the State of Kentucky $11,138,000 for that year and we all know price levels have risen significantly since that time. Treatment of cirrhosis of the liver is further clouded by claims being made on the basis of uncontrolled experiments and the enthusiasm of an author for a therapeutic agent. This likewise is true even of those series reported with follow up by needle biopsies. In portal cirrhosis as diagnosed by needle biopsy, results are almost uniformly good if the hepato-toxic agent is discovered and removed (and this is usually alcohol in my experience) and if the patient will eat a liberal, high caloric, high vitamin diet.

Diagnosis

The importance of early diagnosis of cirrhosis of the liver can not be stressed too strongly. All the textbooks point out

the insidious onset of cirrhosis of the liver and the lack of any specific symptoms. We doctors diagnose only those diseases with which we are familiar and a high index of suspicion is a good asset for finding early cirrhosis of the liver. A history of previous liver disease, exposure to hepato-toxic agents, a poor nutritional history, and alcoholism should make one suspect this disease. Physical findings in early cirrhosis may be nil or consist of the finding of a few spider angiomata or an enlarged liver. The BSP test if abnormal may be a help but is not diagnostic. Of primary importance is diagnosis by direct biopsy especially so called needle biopsy of the liver. From my experience, as verified by needle biopsy, I find no definite benefit can be determined clinically in the treatment of early cirrhosis by the addition of vitamins, lipotropic agents, liver extract or any of the highly advertised proprietary preparations supposedly good in liver disease. I believe the patient is better off spending his money for a high protein diet, than buying expensive commercial preparations and vitamins because there are probably many other valuable food essentials necessary in the treatment of cirrhosis from a nutritional standpoint which are probably not known and which are obtained in a highly nutritious diet.

Most authors in their writings discuss patients who have obvious clinical cirrhosis of the liver by history, physical examination and laboratory studies with or without needle biopsy of the liver. Any patient upon whom the diagnosis of cirrhosis of the liver is made easily from the clinical standpoint is a seriously ill patient. The prognosis in all these patients is a guarded one despite our so called modern day treatment.

Ascites

Ascites is almost invariably a late complication of cirrhosis of the liver. The average expectancy of life after the onset of ascites as given by various authors averages from 1.3 to 16 months[8]. To Patek and Post[9] go much credit for pointing out that the prognosis in liver disease may be altered favorably with emphasis on proper nutrition. In the very ill decompensated patient with portal cirrhosis, treatment is most difficult. Many factors are at work to produce ascites. Especially significant are portal hypertension, lowered blood protein and sodium retention. It has been my experience, as that of many others, that sodium restriction in the diet in a cooperative patient will bring about a loss of ascites in the majority of cases. Kark[2] and others have written extensively on the importance of and methods for sodium restrictions in the diet. Restriction of sodium in the diet however is a most difficult task for the patient, the doctor and the dietitian. Generally speaking restriction of sodium need not be severe to achieve good results. In most instances diets containing between 20 and 40mEq. of sodium per day (approximately 1 to 2.3 grams of sodium chloride per day) will keep the cirrhotic patient dry and/or diminish the amount of ascites. The tolerance of sodium varies apparently in each individual patient and diets have to be adjusted accordingly so far as the amount of sodium allowed. It is a good idea to weigh each patient each day, preferably the first thing in the morning and chart these weights. Rapid weight gain means accumulation of water and points to the necessity for the stricter limitation of sodium. Every psychologic effort should be made to encourage cirrhotic patients to eat. A neat attractive tray containing palatable food is all important. A visit with the patient at a meal time will give an opportunity for the doctor to see how little or how much he does eat as well as to stress the importance of eating. These patients need more calories than the average patient and paradoxically they have less desire to take food. Most diets for cirrhotics should contain at least 3500 calories a day. A dietitian is all important in outlining the prescribed diet to the patient. If one is not available many such diets have been prepared by the various commercial companies (a very good booklet is "Sodium and Potassium Analysis of Food and Waters" and "The 200 Milligram Sodium Diet Outline and Food List" prepared by Dr. Charles E. Bills, Meade Johnson and Company, Evansville, Indiana.)

It has been our experience not to insist too strictly on sodium restriction at the expense of further destroying the patient's taste for food which of course limits the caloric and protein content of the diet. A better therapeutic effect may be obtained by allowing a small amount of salt to make the food more palatable, even if there is an increase in the body weight (water) for a short time, provided the patient will continue to ingest his high protein diet. The use of cation exchange resins capable of removing sodium during their passage

through the gastro-intestinal tract aids in allowing the patient to take a more palatable, high protein diet. Greenman and coworkers[10] have pointed out that the in vivo efficiency of cation resins is usually 1 mEq. of sodium per gram of resin. Ordinarily diets provide 100 to 300 mEq. of sodium daily and since most commercial resins are given to the extent of only 60 grams daily it is obvious that there is an insufficient amount of sodium removed if the dietary sodium is at this high level of intake. It is true that by giving resins sodium restriction need not be as strict but restriction of sodium is of primary importance in the patient with ascites. It has been our experience however that it is difficult to induce a sick cirrhotic patient with anorexia and ascites to take 15 grams of cation exchange resin 4 times a day and we find it far easier to try first a high protein, high caloric, low sodium diet with or without the use of artificial salt preparations. Likewise resins must be used cautiously in the presence of renal disease. When a low sodium dietary regimen is started, especially in patients with known or suspected renal disease in addition to their cirrhosis, it is best to do a weekly non-protein nitrogen test and, when possible, plasma carbon-dioxide combining power and serum sodium and potassium tests at least once a week for the first few weeks after treatment has been instituted.

If the patient is not responding by loss of his ascites with sodium restriction, mercurial diuretics may be a distinct help. It is best to start with a very small amount and be guided by the diuretic response of the patient. One-half c.c. intramuscularly may be effective. However, those patients with severe cirrhosis and much ascites may have little or no response to mercurial diuretics. As a rule this is a very poor prognostic sign and may be correlated with a very low serum albumin. With mercurial diuretics and a good diuresis the protein fraction of the ascites is obviously not lost. In addition to mercurial diuretics, Diamox is being used at the present time as a diuretic in cirrhotic patients with ascites. In general it does not seem to be as effective as mercurial diuretics. I have had one patient however who had a good diuretic response after he had ceased to respond to mercurial diuretics. A hypertonic 10% intravenous glucose solution in water may be used as a diuretic, but in my experience is not very effective and it is probably more effective solely from the nutritional standpoint. Abdominal paracentesis should never be resorted to unless all of the above mentioned means have failed in their attempt to remove the ascites and the massiveness of the ascites itself causes so much discomfort to the patient that abdominal paracentesis is deemed necessary.

Salt poor human albumin has been used extensively in the treatment of cirrhosis by others[11]. In our experience however, it is so expensive if used in adequate amounts and the result is so indefinite and hazardous at times, that we found it impractical to use. It is usually given as 100 c.c. of a 25% solution intravenously once a day.

In the treatment of a cirrhotic patient by salt restriction and with the use of mercurial diuretics, Diamox, and abdominal paracentesis, one must be aware of the so called low salt syndrome. The patient will usually complain of marked prostration, weakness, muscular cramps and abdominal pain. In these patients the serum sodium may be found to be as low as 130 mEq. per liter. The blood urea will rise, the carbon-dioxide combining power of the plasma drops and the patient eventually dies in uremia if not treated with hypertonic saline. A 5% solution of sodium chloride in the amount calculated to replace a specific sodium deficit in the extra cellular compartment may be used to correct the low salt syndrome.

Treatment

For the very ill cirrhotic patient when seen initially, and when that patient is unable to eat the diet as prescribed, the use of water soluble vitamins, parenteral protein and lipotropic agents, may be of some temporary benefit. Needless to say all parenteral preparations should be sodium free. Intravenous dextrose therapy is a time honored remedy in cirrhosis. If the patient can eat however it offers no apparent clinical benefit to give added glucose intravenously. In the very ill cirrhotic we prefer to use 10% invert sugar in water with added water soluble vitamins in large doses plus the use of parenteral protein (1000 c.c. of 10% invert sugar plus water soluble vitamins and 1000 c.c. of amino acid solution administered intravenously each day.) It has become routine to give supplementary vitamin B complex in the management of cirrhosis of the liver despite the fact that in very few cases is there any evidence of any vitamin B defi-

ciency. It is impossible to evaluate the effect of vitamin therapy without a specific deficiency. There is experimental evidence[12] to show that nicotinic acid in large doses may be harmful in the presence of a fatty liver. Likewise a possible anti-lipotropic effect has been implied. Dry yeast is a time honored therapeutic agent used in cirrhosis but in my experience most of the patients refuse to take the various preparations offered no matter how they are masked to cover the taste. In the presence of hypoprothrombinemia, vitamin K is given parenterally in amounts of 5 to 10 milligrams daily. However it is our experience that with severe liver damage the use of vitamin K has little if any effect in overcoming this defect. If there is improvement it is usually a very slow process and occurs as the general function of the liver improves. Massive doses of vitamin K are of no value and indeed as pointed out by others may be injurious.

Lipotropic agents are difficult to evaluate in humans. If the patient has a good appetite I feel they are not needed as a therapeutic agent. Clinically the best reports have been made on patients who have been found to have enlarged, fatty livers. In the absence of fat or enlargement of the liver due to fat it is very doubtful that lipotropic agents have any value at all. By using needle biopsy for evaluation we have seen 50% of the fat disappear from the liver in 3 weeks time when the patient was on a high protein diet and no other therapy was offered. The amount of choline and other so called lipotropic agents in a high protein diet is probably more than adequate. The use of crude liver extract parenterally has been another time honored remedy in the treatment of cirrhosis of the liver. Again this is a therapeutic agent most difficult to evaluate and one which has never been evaluated adequately. Intravenous liver extract likewise has been recommended and used. One of our patients over a five year period received 536 injections of such an intravenous preparation (Intraheptol) giving 50 c.c. per injection. Even in this case it was difficult to say that the liver extract contributed anything specific to treatment. During the last year of life the treatment was intensified but was useless in preventing a rather typical death from cirrhosis and the patient died with severe ascites.

ACTH or cortisone has been given to 12 patients seriously ill with cirrhosis of the liver. No definite improvement from such therapy could be noted in any patient. Three patients seemed to eat a little better. Five of our patients were comatose at the time cortisone was given. All of these patients died. Many unfavorable reports concerning the use of ACTH and cortisone are known.

Bed rest in advanced cases of cirrhosis of the liver, especially those with decompensation, is most valuable and is certainly a simple, inexpensive form of treatment all too frequently overlooked. Improvement of hepatic circulation with the body resting in the horizontal position enables the impaired liver to perform its functions in a more normal fashion[13].

My own experience dates from 1945 when I returned from military service to continue my specialty training at the Cincinnati General Hospital. Since that time I have done over 800 needle biopsies of the liver. Our early experience has been reported elsewhere[14,15]. Of these needle biopsies 546 have been done in private practice. A total of 181 patients were found to have portal cirrhosis of the liver in all degrees of severity. 27 patients were found to have almost complete replacement of the liver by fatty infiltration with little evidence of fibrosis. One patient has had 8 needle biopsies of the liver to follow his clinical course of cirrhosis over a period of 5 years. Two patients have had 3 biopsies for follow up of therapy. Fourteen have had 2 biopsies to study the progress of their disease. I can not give an accurate breakdown of the follow up of these 181 patients who have proved portal cirrhosis. Many of them were seen in consultation for other doctors. In general it can be said that those patients who were not decompensated and who cooperated by eating and stopping the use of alcohol, where alcohol was a secondary factor, have done well. Two patients have been followed for 6 years. They were seen initially with viral hepatitis proved by needle biopsy. Both used alcohol. Following the episode of viral hepatitis both patients followed a steady downhill course and died with a typical clinical picture of portal cirrhosis. Thirty two patients with severe cirrhosis and ascites are still alive after periods varying from 4 to 6 years. Seventy six patients are known to be dead. It must be said that the majority of these patients could not or would not cooperate, some because they could not eat and the majority because they refused to give up alcohol.

One female patient died at the age of 64 with severe portal cirrhosis. She never used alcohol in any form. However, she gave a lifetime history of prolonged migraine headaches lasting as long as a week and during these times of severe headache she consumed little if any food. There was no history of other liver disease or hepato-toxic agents. It is assumed that mal-nutrition secondary to the anorexia induced by migraine headaches was the sole factor in producing this cirrhosis. This patient came to autopsy and no other significant pathology was found.

Case Presentations

Three cases have been chosen for brief presentation. The first case is that of a 36 year old white male with a history of heavy alcoholism for 7 years and little ingestion of food. He was seen because of gradual onset of edema of one week's duration. The liver edge was 8 cm. below the right costal margin. Both legs were edematous as high as the knees with signs of peripheral neuritis. The cephalin flocculation test was negative at 48 hours. The prothrombin time was normal. The BSP test showed 17% retention of the dye. The AG ratio was within normal limits. Sections showed severe fatty vacuolization and a moderate amount of fibrosis with considerable round cell infiltration. The patient was kept in the hospital 2 months on strict management with a high protein, high vitamin, low salt diet and extra vitamins. He was given Intraheptol 50 c.c. intravenously twice a week plus large doses of choline, methionine and cystine. Clinically he slowly improved. The edema left and his appetite improved. The next needle biopsy was made 2 months after intensive treatment and hospital supervision. Before this biopsy was made the cephalin flocculation and thymol turbidity were still normal. The BSP retention fell from 17% to 1%. This biopsy showed approximately 50% reduction in the amount of fat and there was distinct evidence of portal fibrosis with moderate inflammatory reaction. This is an example of prolonged intensive treatment under optimum management in the hospital with very slow improvement as evidenced by needle biopsies of the liver.

The next case is that of a 43 year old business man who was seen for a routine check up. His only complaints were vague ones related to indigestion. He was well nourished. A few small spider angiomata were seen. The liver edge was palpable only on deep inspiration. As near as I could find out from him and his wife he consumed an average of 6 bottles of beer a day and had done that for 15 years. He had 10% BSP retention after 45 minutes. The A/G ratio was entirely normal as was the cephalin flocculation. His first biopsy of the liver showed marked alteration from normal. There was evidence of increased fibrosis and moderate fatty infiltration. The patient was warned about his alcoholic ingestion and was instructed in a high protein, high vitamin diet. He was given supplementary amounts of vitamins and oral lipotropic agents. He stayed on this therapy for one year but continued to drink one or two bottles of beer every day. Both he and the wife insisted his alcoholic ingestion was cut down but he never actually quit drinking. The second biopsy was made a year later and still showed rather marked fatty infiltration with occasional small foci of necrosis involving one or two cells and some increase in the portal connective tissue. A BSP test done shortly before the second biopsy showed 5% retention of dye at 45 minutes. The patient is an example of a supposedly intelligent individual of good economic means who took large doses of oral vitamins and lipotropic agents and an increased amount of protein in his food for an entire year but likewise continued to drink alcohol but in a diminished amount compared to his previous intake. By biopsy he showed little if any improvement at the end of one year.

The third case is that of a white male who was first seen at the age of 31 and followed over a period of 5 years with several hospitalizations. During this time 8 liver biopsies were made. All of them were made from the same point of entrance, using a transthoracic approach. At first this man cooperated very poorly. His liver biopsies confirmed what was seen clinically in that he was getting worse because of his continued drinking and poor intake of food. His first liver biopsy showed only slight fatty vacuolization and some focal liver cell degeneration (a so-called toxic hepatitis). Subsequent biopsies showed increasing amounts of fatty vacuolization. A biopsy made at a time when he was admitted to the hospital because of a generalized convulsion during an episode of prolonged drinking showed diffuse, severe, fatty infiltration and increased fibrosis with moderate lymphocytic infiltration. It represents the patient's fifth liver

biopsy in the fourth year of his observation. He was slightly icteric. The cephalin flocculation was 3 plus at 24 hours. The A/G ratio was normal and the BSP test showed 12% retention at 45 minutes. The liver was enlarged being 4 cm. below the right costal margin. It was not tender. Following his convulsion, the patient for the first time made an effort to cooperate. He quit his drinking and his appetite improved. He took a standard vitamin capsule once a day. The patient's eighth liver biopsy was made one year after the previous biopsy. All the laboratory studies were normal at this time. The patient still had many spider angiomata. The liver cells were essentially normal. There was little if any evidence of portal fibrosis and no evidence of fat. The only abnormality found was some inflammatory reaction of moderate severity. This man is doing well and is very active in "Alcoholic's Anonymous" at the present time.

Conclusions

In conclusion, the incidence of cirrhosis of the liver is probably increasing and is certainly much higher than most of us are aware. Only by early diagnosis and correcting the malnutrition and removal of the so-called hepatotoxic agent which in my experience is usually alcohol can one hope to alter the morbidity statistics for this disease. I would stress that in evaluation of treatment an early diagnosis must be proved and the best way to prove it is by needle biopsy of the liver. The changes of early cirrhosis, especially fatty infiltration, are reversible and probably completely reversible since the action of most hepatotoxic agents is self limited and removal of such an agent will allow the liver to recover its function. If one waits until the clinical diagnosis of cirrhosis is made by very obvious physical findings then treatment is most difficult and the prognosis is still poor even though with the so-called modern therapeutic agents life may be increased a few more years. The treatment of the decompensated cirrhotic is not the primary problem. Early diagnosis of cirrhosis is the primary problem and prevention of the clinical picture of the dying cirrhotic with decompensation is all important.

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Urine*

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Urine is undoubtedly the most simple and accessible laboratory material that the physician has available for diagnostic and therapeutic assistance. However, the repeated appearance of "QNS" opposite the tabulation "Sp. Gr." on the laboratory slip is mute evidence of the technician's disdain for this odoriferous material which consistently clutters her laboratory doorstep.

In considering urine with reference to its indication of pathology two major topics may be discussed: 1) the characteristic acts of expelling urine as an indication of various disease states and 2) its abnormal properties in numerous diseases. In this dissertation we will be limited to the latter aspect; the clinical interpretation of physical, chemical and microscopic observations. The analysis of urine has both diagnostic and therapeutic values and we shall attempt herein to discuss both.

The significance of urinary findings is entirely dependent upon the proper collection of the urine specimen. If the sample of urine is improperly collected the examination will be useless and the findings valueless.

Collection

The only method of collecting a satisfactory urine specimen in the female is by catheter. A voided specimen, irrespective of the amount of preparatory vaginal cleansing, is diagnostically valueless. This applies to the adult and child alike. In the child, to prevent fright and pain, it is simple enough to administer a short inhalation anesthetic; ie., ethyl chloride. It is to be emphasized that this has reference to diagnostic specimens and later as we watch the progress of improvement in urinary tract infection we may use voided specimens as a rough index, but never are they nearly as reliable as the catheterized specimen. The need of continued catherterized specimens or the use of voided urine in following progress must be tempered by good judgment on the part of the physician and certainly no fixed rule can be applied. However, for the initial diagnostic specimen in the female it must be obtained by catheter on every occasion and there is no exception!

Just a few words about catheter sterilization. They must be sterilized by boiling or steam. Chemical solutions are not dependable since they often coat the infected area of the catheter and inhibit the growth of bacteria only to have the next urine culture reveal the presence of the bacteria which were present in the catheter and not a part of the clinical picture at hand.

Collection of the specimen in the male should never be accomplished by catheter. The patient is asked to void and after an ounce or so is voided a bottle or culture tube is passed under the uninterrupted urinary stream to obtain the urine which is passing through the urethra that was cleansed by the initial ounce of urine. If collecting urine for a culture the same procedure is applicable except that the glans is cleansed beforehand with 1:2000 oxycyanide of mercury or alcohol. The only time that this method of obtaining urine is not applicable is when the patient is being cystoscoped and the urine specimen is collected through the instrument.

In the male the urine specimen should be collected in two or three bottles. These bottles are filled without interrupting the urinary stream between bottles. The first bottle, containing approximately one ounce of urine, reveals the contents of the urethra which are washed out in the initial urinary stream. The second bottle, a sample of the bladder urine without urethral contamination, is a true picture of the bladder urine. The third bottle is collected as the urinary stream ends and there is a contraction of the urethral sphincters; this demonstrates the posterior urethral contents as it is compressed and its periurethral contents expressed into the last few drops of urine. This may, in instances of acute infection and edema, express some blood and thus be indicative of an acute inflammatory process of the vesical neck and posterior urethra.

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Examination

In examining the urine specimen in the male significant information may be obtained by simple accurate observation. The presence of various typical shreds in the urine is most helpful diagnostically and therapeutically. Fundamentally there are three types of urethral shreds found in urine:

1. Long, mucous filaments which float in the urine signify superficial mucosal irritation or congestion rather than deep seated inflammatory lesions.

2. Thick, heavy shreds which rapidly sink to the bottom contain pus and are indicative of subacute infections. These shreds, fished out of the urine and stained, will often reveal gonococci in instances of scant urethral discharge when examination of the urethral discharge has been unsatisfactory.

3. Comma shreds occur as either large or small comma-shaped mucoid structures in the urine and are indicative of chronic urethral infection. The larger comma shreds occurring in the first or third glass are indicative of prostatic infection. The smaller comma shreds appearing in the first glass only are evidence of anterior urethral infection or littritis (chronic inflammation of the glands of Littre).

Color

Normally urine is yellow in color due to the pigment of urochrome and its depth of color is dependent upon its concentration and acidity. The concentration of urine is wholly dependent upon the reabsorptive ability or the reabsorptive opportunity of the renal tubules. If, for example, the patient ingests huge quantities of fluid the tubules are overwhelmed and there is little opportunity for water reabsorption as well as little reason, since the body is adequately hydrated, and the excess water is permitted to pass on to the bladder for discard. On the other hand, in renal disease the tubule is functionally impaired and thus can not successfully reabsorb the necessary water which is lost to the bladder and a hydration deficit may be created. In both instances the urine appears dilute and colorless. Variations in color of urine may be significant.

1. A deep yellow color is found during vitamin B complex therapy and after ingestion of large quantities of fruit (peaches). This urine characteristically has a slight suggestion of fluorescence.

2. An orange yellow color of urine may follow such medication as pyridium, serenium, salicylates and acriflavine. Hepatic disease may demonstrate this color urine before the skin and conjunctival jaundice appears. This urine reveals a yellow froth in contradistinction to the colorless froth of other highly colored urine. In hemolytic anemia the urine is not of abnormal color.

3. A red urine may be due, in addition to blood, to eosin used to color sweetmeats, pyramidon, the porphyrin group, phenolphthalein, antifebrin, sulfonal, trional, fuchsin, bilberries and beets.

4. Blue or black urines are of two distinct groups: 1) those that are black on being passed (extreme examples of severe jaundice, hemoglobinuria, methemoglobinuria and porphyrinuria) and 2) those that are brown and turn darker on standing (such drugs as salol, phenylhydrazine and salicylates). Another example of this group is indicanuria which signifies marked protein decomposition in the alimentary tract.

In melanuria the urine passed is of normal color and turns black upon exposure to light. Urine with this property occurs only when the tumor has spread beyond its primary site.

Alcaptonuria is due to an inborn metabolic error which is transmitted as a Mendelian recessive characteristic and resembles the urine of melanuria. It can be distinguished since dilute ferric chloride causes a deep blue in alcaptonuria instead of the intense black found in melanuria.

5. The green and blue urine due to Methylene blue is of common knowledge.

It is apparent then that to observe accurately and record the color of urine may reveal valuable information to the clinician. Certainly the cherry red color of pyramidon toxicity or the pale red urine of the patient having taken a phenolphthalein laxative can hardly be confused with hematuria. The urine color may suggest previous medication or initiate a search for the melanoma or it may be apparent that the patient's unusually chrome yellow urine is evidence of his vitamin enthusiasm.

Cloudy urine is not necessarily an indication of infection, blood, bacteria or chyluria, but may be due to precipitated urates, carbonates, phosphates or oxalates. The chemical causes for cloudy urine are usually of no clinical significance. Chyl-

uria is due to either parasites or causes not well understood such as is seen in tuberculosis, aneurysm, diabetes, leprosy, trauma, pregnancy or obstruction of the vena cava. To distinguish these causes for cloudy urine the microscope is the only method of absolute accuracy.

Specific Gravity

This brings us to the consideration of the specific gravity of urine. The value of the first morning urine, when no fluids have been taken for several hours, permits a rough estimate of the renal function and this information coupled with the plasma urea nitrogen or non-protein nitrogen level affords information in managing the patient's fluid balance.

It is known that the normal healthy adult must excrete 35 grams of urinary solids per day and this can be accomplished in 500 cc. of urine. However, if this patient can concentrate the urine only to 1.010 it will require at least 1400 cc. of urine to eliminate 35 grams of urine solids. Hence, the latter patient unless given water in excess of 2600 cc. (1400 cc. + 1200 cc., basic need for solids excretion + insensible water loss) there will soon be evidence of dehydration. The knowledge of the potential span of renal concentration is necessary for intelligent management of fluid therapy. For example, if the patient's maximum urine concentrating ability is 1.010 it is essential that sufficient fluid be given to keep the specific gravity of the urine below 1.010 in an effort to avoid undue taxation of the renal function and thus further damage an already disturbed functional unit.

The above considerations have reference to the therapeutic indications of specific gravity and it is well now to mention its outstanding diagnostic attributes. A clear urine with a specific gravity of more than 1.028 is almost certainly that of a diabetic unless the patient has recently had an intravenous pyelogram and the specific gravity is altered by the organic iodide present in the urine. If the specific gravity is less than 1.005 and the urine is water clear it is usually a sign of diabetes insipidus or over hydration.

Reaction

The reaction of the urine is diagnostically and therapeutically important. Litmus paper changes color at an alkaline pH so that it is not a good indicator for accurate reporting. Nitrazine paper is a very satisfactory indicator using the color scale furnished with the paper estimating the pH. All tests must be made on fresh urine since ammoniacal decomposition sets in quickly.

Marked alkalinization of the urine is associated with ureasplitting organisms (Bacillus proteus or staphylococcus). Acid urines are common in infections of the colon group and in tuberculosis. Also, the urinary antiseptics function more effectively at specific urine reactions (streptomycin in an alkaline urine, penicillin in acid, etc.). Hence, the reaction of urine is extremely useful in managing urological infections.

Albumin

The presence of albumin in the urine is an indication of glomerular dysfunction and the amount of albumin is a measure of glomerular damage. In determining the amount of albumin the supernatant centrifuged urine must be used, otherwise the test for albumin is only an estimation of the protein content of the pus and blood content of the specimen.

The amount of albumin present will assist greatly in differentiating various renal diseases; ie.,

Acute Nephritis	Chronic Nephritis	Nephrosis	Pyelonephritis
3-4+	1-2+	4+	Heavy Trace

The reason for the marked albuminuria in acute glomerular nephritis and nephrosis is that in these diseases there occurs marked glomerular damage and in the instance of nephrosis there is an added fatty degeneration of the proximal tubule which affords excessive water reabsorption and thus complements the marked edema associated with proteinemia. In instances of pyelonephritis and chronic nephritis the glomerular lesion is either minimal or there occurs a complete obliteration of the glomerular filter. Hence, the affected portions of these kidneys are without functional glomeruli from which to lose albumin.

Albumin may be the only finding in septic infarcts of the kidney associated with bacterial endocarditis or uninfected thrombotic renal infarcts. Furthermore, cardiac lesions with congestive failure reveal marked albuminuria due to functionally disturbed glomeruli occasioned by cellular anoxia from an inadequate renal circulation. The catabolic factors of fever

may cause transient albuminuria, but this disappears promptly with recovery. Albuminuria may occur during great muscular activity as is seen in oarsmen who before the race have normal urine, but after the race may have urine loaded with albumin which immediately disappears. This again is an example of catabolic activity and temporary albuminuria that is without clinical significance.

Physiological or orthostatic albuminuria is a condition which is associated with normal activity and disappears during bed rest. The etiology is unknown though it is more common in adolescents and may disappear during later life. Renal function is normal and cardiovascular disturbances are absent. Its only significance is the economic burden which it places on these patients in that they are unable to obtain adequate life insurance.

Albumosuria (Bence Jones) is a condition in which, when acidulated urine is heated to 60°C., a heavy white cloud appears which disappears as the urine boils and reappears as the urine cools. This condition is associated with marked tissue putrefactions such as severe prolonged pyogenic abscesses, with hepatogenous conditions such as yellow atrophy, cirrhosis, suppurative pyelophlebitis, infective cholangitis, and with leukemic processes and multiple myeloma. It is important to remember that this test may be intermittently positive.

Microscopy

The most accurate instrument for the examination of the urine is the microscope. It is a simple procedure that must be carefully performed and accurately interpreted. The urine should be centrifuged so that the greatest number of abnormal cells may be seen per unit volume of urine. The urine is spun at high speed for thirty seconds, the supernatant urine which is virtually free of cellular elements is used for chemical tests and the sediment studied with the microscope.

The microscopic examination of urine includes routinely: 1) presence or absence of pus, blood cells or epithelial cells and the amount, 2) the presence or absence of bacteria and their motility or lack of motility and 3) the presence or absence of tubular casts.

Pus cells may be confused with small epithelial cells if the nuclei are not too distinct; however, by the addition of a drop of dilute acetic acid the lobulated leucocytic nuclei are emphasized and the differentiation is apparent. Before adding acetic acid the presence of blood cells must be determined since the acetic acid will abruptly dissolve red blood cells which are seen as biconcave nongranular discs which are smaller than epithelial cells. Also, the presence and motility of bacteria must be determined since the acetic acid will halt their motility. Contrary to popular belief the size and shape of epithelial cells is of no significance. The presence of epithelial cells in exaggerated numbers suggests the possibility of leukoplakia of the urinary tract, tumor or the healing of a recent urinary tract infection.

Urine sediment stained to observe the morphology of the bacteria is of utmost importance. Often in the primary smear several bacteria are evident which are missed on culture and thus with some experience the primary smear is more useful than culture studies. It must be admitted, of course, that culture with sensitivity tests is extremely useful in an intelligent therapeutic attack on a complicated urinary tract infection.

A urinary cast constitutes the washed out mold, so to speak, of a renal tubule and its importance lies in its presence in relatively large numbers in the urine. Casts are not found in pyelonephritis since the connecting glomerulus is functionally inert and thus no fluid is available to wash the cast out of the tubule. The exact type of cast is of some interest in suggesting the degree of infection though actually of no therapeutic value.

Summary

This presentation lacks much in outlining either the significance or methods of urine study. It is hoped, however, that it will reemphasize the importance of careful and accurate urinalysis in clinical medicine.

Case Discussions *

FROM THE LOUISVILLE GENERAL HOSPITAL

A Case of Congenital Diaphragmatic Hernia

Presentation of the Case:

Harold E. Kleinert, M.D.

Department of Surgery

Diaphagmatic hernia in the newborn is not an unusual cause of respiratory difficulty. Early diagnosis is important and can be made by physical examination and chest x-rays. Prompt operative treatment is imperative.

Baby Girl H., Case No. 25464, Louisville General Hospital

A newborn delivered at 7:25 P. M., 3/25/54, after a forty week gestation period. The mother was a seventeen year old primipara. Her prenatal course was normal. Delivery was accomplished with low forceps under pudendal block anesthesia, following a ten hour and thirty minute labor. The baby cried immediately and spontaneously after birth.

Physical Examination

Weight, 5 lbs. 5 oz. Length, 48 cms. The baby cried well, but was cyanotic. The examiner believed the lungs were aerating adequately. The heart was completely normal as was the remainder of the examination.

The baby was placed in a Gordon Armstrong incubator with oxygen. The following morning, 3/26/54, the baby appeared improved; however, when taken out of oxygen, she again became cyanotic. Examination at this time revealed respirations to be 90/minute. Expansion of the chest on the left was diminished. Auscultation of the thorax revealed no breath sounds on the left, except for dense rales at the base. Clinically, atelectasis of the left lower lobe was suspected and a chest x-ray was obtained. The films were interpreted as indicative of a left diaphragmatic hernia (See illustration.).

Operation

Preoperatively, glucose in water was given slowly through an ankle vein cutdown. The baby was typed and crossmatched for a 250 cc. whole blood transfusion.

At 3:00 P. M. on 3/26/54, under endotracheal ether oxygen anesthesia, emergency operation was performed through an upper abdominal incision. The left pleural cavity contained all of the small bowel and most of the colon and stomach. The abdominal viscera were withdrawn from the left thorax and a large posterolateral left diaphragmatic hernia repaired. The lung was expanded with catheter suction in the pleural cavity, the catheter being withdrawn as the last suture was tightened. There was evidence of incomplete rotation of the gut, but no congenital bands or areas of atresia were found. The operative procedure required one hour and ten minutes. Body heat was conserved by a warm water bottle during the procedure.

Postoperative Course

Oral fluids were withheld the first twenty-four hours. The nasopharynx was carefully aspirated to remove mucus and fluid as it accumulated. The patient was observed frequently for evidence of respiratory embarrassment and a portable chest x-ray was obtained the evening of operation. The temperature of the isolette was regulated to maintain body temperature at 98-99° F. In addition, the patient received antibiotics.

Thoracentesis was performed on two occasions to remove accumulated air from the left pleural cavity.

Some feeding difficulty was encountered during the first four postoperative days, necessitating administration of parenteral fluids, but by 4-1-54 the baby was retaining the formula well and steadily improving.

She was discharged in good condition on 4-7-54. Weight at that time was 5 lbs., 3½ oz.

Discussion

Lawrence A. Davis, M.D., Department of Radiology; "Simple x-ray examination will generally establish the diagnosis of diaphragmatic hernia. In the average case, the affected pleural cavity has a bizarre, bubbly appearance from the entrap-

ped air-filled intestines. The heart and lung are displaced to the opposite side with compression of the lung. The liver or spleen may also enter the pleural cavity. In most cases it is unnecessary and even unwise to give the infant barium.

The accompanying illustrations, taken from the films made in this case, demonstrate the typical findings. Note that postoperative chest film is entirely normal."

Hugh B. Lynn, M.D., Department of Surgery: "Congenital diaphragmatic hernia represents one of the most urgent emergencies of the newborn. The traditional viewpoint that diaphragmatic hernia should come to surgery only after the youngster had survived the neonatal period was based on the theory that if he could not survive with his hernia he could not survive surgery. Under that regime only 1 out of every 4 did survive. Therefore, we must now consider this an acute emergency; the earlier the diagnosis is made the better is the chance for success.

Although the baby was cyanotic, the examiner believed the lungs were aerating adequately. This is a common finding for two reasons: first, in a crying newborn infant the transmission of breath sounds is pretty universal throughout the thorax, and secondly, immediately after birth before there is adequate swallowing of air to distend the loops of intestines in the thorax, there is still some space for the lungs to expand. Chest films immediately established the diagnosis. The early diagnosis more than anything else was responsible for the completely uneventful and satisfactory outcome of this case.



Figure 1. Chest showing typically bubbly appearance of left hemithorax due to air-filled intestines. The heart and left lung are displaced to the right.



Figure 2. Chest 10 days postoperaitvely. Normal.

At operation through an abdominal incision the youngster was found to have the most prevalent form of congenital diaphragmatic hernia; that is, a posterolateral defect, or hernia through the foramen of Bochdalek. The facts that the lesion was on the left side and that there was no hernial sac also are typical of the predominant form of diaphragmatic hernia. The incidence of associated incomplete intestinal rotation runs as high as 30-35%; frequently there are associated peritoneal bands crossing over the duodenum with the hazard of incomplete intestinal obstruction. Incomplete rotation coupled with an abnormal small intestine mesentery may lead to volvulus. Another peculiarity of diaphragmatic

herniae in the newborn is that due to long residence of loops of intestines in the thoracic cage, the abdomen has not been distended to provide space for full abdominal contents. These considerations made an abdominal approach preferable to the thoracic incision more commonly used in older children and adults.

Too much emphasis cannot be placed on the importance of early detection and immediate surgical correction of this lesion. This is true regardless of the size or extent of the hernia, and to a lesser extent in spite of the condition of the patient. The vitality of these youngsters, particularly after the first forty-eight hours of life, is so unpredictable that it is unwise to maintain them in an incubator on parenteral fluids beyond this period in the hope that the general condition will further improve. The chance of survival without operation is so small that it is wiser to open the abdomen immediately and reduce the hernia, even if this must be done with only local anesthesia and oxygen administration.

Cancer of the Lip

ANDREW M. MOORE, M.D.

Lexington

This presentation is neither original nor startling. It is a reiteration of certain principles which must be followed if cure is to be obtained. Cancer untreated is universally fatal unless death from some other cause intervenes. This does not apply just to the more dramatic cancers of the lung and stomach, or the rectum, but also to those lesions, which are too often regarded casually and "touched up" with cautery or given a "shot" of x-ray.

The successful treatment of cancer depends upon four cardinal principles:

(1) The early recognition.

(2) A positive diagnosis.

(3) Adequate therapy.

(4) Persistent follow-up.

The first-mentioned principle demands a high index of suspicion. Any ulcer or lesion which persists or grows over a two-to-four week period should be investigated. Certain pre-cancerous conditions, such as keratosis and leukoplakia, areas of radiation dermatitis and other neoplastic diseases with a malignant potential should be removed. In adults, the appearance rather suddenly of a mass in the neck is, as a rule, not an inflammatory manifestation.

The establishment of microscopic characteristics is essential for the proper treatment. A biopsy must be taken which is representative. It must be properly prepared and examined by a competent pathologist. A negative biopsy does not rule out the presence of malignancy.

It cannot be stressed too greatly that the physician who first treats a cancer is the one who has available to him the best chance for cure. The methods of treating cancer today are being constantly enlarged. At present adequate surgical excision appears to offer the best means of attack in most cases of cancer of the lip.*

Even in the best of hands, due to a variety of circumstances, lesions may recur or metastatis may develop. However, it is the consensus of opinion at the present time that prophylactic neck dissection for carcinoma of the lip is not routinely indicated. Patients should be seen at frequent intervals for at least two years following the removal of a carcinoma of the lip.

*Editor's Note: The scientific consultant who reviewed this article is of the opinion that, "Most dermatologists consider proper radiation therapy as effective as surgery in the treatment of carcinoma of the lip where the growth is localized and no metastases have occurred."

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SPECIAL ARTICLES

OUR INVESTMENT IN RURAL HEALTH

EDWARD J. McCORMICK, M.D.

President, American Medical Association

I understand the slogan of this meeting has been "Put the 'U' in Community". You certainly have during the past few years put the "U" in community, and I want you to know, those of you who are not doctors, that the medical profession of this great country is indeed grateful to you. We all hope that cooperation between the medical profession and the rural groups will continue until every rural area in our great country is supplied with the best that medicine can give.

One of the most important activities in which the American Medical Association and its Rural Health Council has engaged is the Physicians Placement Program.

The experience in Texas and Kansas and in many other states is evidence that the physicians of the United States of America have made their placement program a tremendous success.

Many organizations, state medical associations and others are awarding scholarships to young men and women who intend to practice in rural areas. The Deans of many of our medical schools, I am happy to report, are stressing the importance of general practice and rural medicine, instead of encouraging a trend in the direction of specialization.

The American Medical Association, as you know, has continually supported the Hill-Burton Act, which has made it possible for many smaller communities to build hospitals. I am happy to report that many of these hospitals are rendering care which is comparable in every way to the service accorded in the large hospitals and clinics of our great cities.

One of the main complaints which I have heard from doctors in my travels about the country is the fact that excellent doctors in many small communities are frequently by-passed by patients in the neighborhood in favor of some "big name" practitioner, perhaps thirty or forty miles away. The doctors who are in rural areas should receive the support of all people in the community in which they settle.

I am happy, too, with the increase in the past year or two of the number of medical schools in the United States. I am likewise pleased with the work which is being done by the National fund for Medical Education, and by the American Medical Education Foundation of the American Medical Association, to raise money for the expansion of medical education facilities.

Those of you who are familiar with education must remember that no student actually pays his way through college, and especially through medical school. No medical school could exist on tuition receipts alone. I think the last figures I heard were to the effect that 20% of the income of medical schools was derived from physicians, and it has been necessary for us, therefore, to ask our doctors all over the country, our friends in industry, and our friends in business, to help support medical education in order that more and more graduates can be produced, especially for the rural areas.

The results during the past few years have been excellent, and we expect the fund drives to grow. The building of medical schools, and the expansion of medical schools in rural states is indeed encouraging.

The American Medical Association and its member doctors are happy about this expansion of medical education facilities. We have more doctors in America than any other country in the world, with the exception of Israel.

Our problem has not been one of numbers, but of distribution. The placement of doctors in rural areas shall be carried on through the combined efforts of the

*Address before the Ninth National Conference on Rural Health, March 6, 1954, Dallas, Texas.

American Medical Association and the various farm groups.

I have always been convinced that there is no problem in America which cannot be solved on a voluntary basis, and in kepeing with the fundamentals of our Constitution.

We do not need federal aid or federal intervention in the medical picture. We can do the job ourselves. And we have proved during the past few years that it can be done on a voluntary basis.

Rural people are self-reliant, and all Americans should be so if we expect to preserve our freedom. People in rural areas, I am sure, would rather work for a better community than sit by and wait for someone to provide needed improvement on a silver platter. I find this to be true wherever I go—from Maine to California. There is little doubt in my mind that a continuation of federal handouts, initiated during the past twenty years, would eventually lead the American people to serfdom.

The cooperation of the farmers of this country with the Council on Rural Health of the American Medical Association is a great step forward in the preservation of the America which we all love.

You members of the farm groups have demonstrated that insurmountable obstacles are of little moment, and that a good job can be done in the health field in rural areas without the cold and paralyzing hand of Federal dictate.

It is the aim of the American Medical Association to make medical care available to all the people in this country, whether they can pay for it or not, and the doctor who recognizes the function of his duties thinks not in terms of a fee, but of what he can do for suffering individuals.

Doctors' fees, by the way, have risen less during the past ten to fifteen yaers than the cost of any other commodity.

I want to say to you from the bottom of my haert that American medicine is proud of the cooperation which it has received from the farm people, and that we will continue to interest ourselves in rural health until such time as we are satisfied that the best medicine is available in rural areas, and until such time as those living in rural areas agree with us that the task has been accomplished. Even at that time, when it arrives, we should not become complacent, but should continue to cooperate and preserve the goal which we shall have attained.

Our goal should be, first—better and more available medical care for all the people. And second—the preservation of the form of government which in 178 years has made the United States of America the farm center, the industrial center, the business center, and the medical center of the world.

May I say to you all, doctors and farmers—American citizens—that we are living in the greatest country in the history of the world, a country which is at the present time in great danger, because there are those who no longer recognize the existence of a Supreme Being; those who no longer recognize the individual rights of Man. And while we are talking about our problems of medical care, let us not forget that we also have the problem of preserving America. May God bless this great country of ours.

Thank you so much.

Plan to Attend

THE K. S. M. A. ANNUAL MEETING

September 21, 22, 23

Columbia Auditorium **Louisville, Ky.**

The JOURNAL of the Kentucky State Medical Association

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EDITORIALS

FRED WHARTON RANKIN

The University of Louisville School of Medicine has had its full share of quality in its professors. Among the most distinguished of these was Fred Wharton Rankin, M.D., who died on Saturday, May 22, 1954. Long and vividly will his memory live.

Fred Wharton Rankin was born December 20, 1886, in Mooresville, North Carolina, the son of Watson Wharton and Margaret Houston Rankin. He attended Davidson College, North Carolina and received his A. B. degree in 1905. Doctor Rankin attended the University of Maryland from which institution he received his M. D. degree in 1909, this was followed by an internship and an assistant residency in the University of Maryland Hospital extending from 1909 to 1912. During 1913 to 1916 he was assistant demonstrator of anatomy and associate in surgery at the University of Maryland. In 1916 he became a fellow in surgery at Saint Mary's Hospital and the Mayo Clinic, Rochester, Minnesota, extending to 1922. In 1922 Doctor Rankin was made professor of surgery at the University of Louisville and remained there until the close of the session in 1923.



Dr. Rankin

In 1926 he became associate professor of surgery at the University of Minnesota Medical School, Mayo Foundation, and was chief of a surgical section at the Mayo Clinic until 1933.

Doctor Rankin became a resident of Lexington in 1933 and entered the private practice of surgery where he was chief of the surgical staff of Saint Joseph's Hospital, and professor of clinical surgery in the University of Louisville.

During World War I Fred Rankin served seventeen months with the medical corps, with the rank of Major attached to the 1st A.C. 4th and 26th Divisions in France. He was commanding officer of Base Hospital No. 26 (University of Minnesota Unit), and at the end of the war he became a Colonel in the Medical Corps of the United States Army.

During World War II Doctor Rankin was called to active duty on February 1, 1942 to the Surgeon General's Office with the rank of Brigadier General, as Chief Consulting Surgeon to the Armies of the United States. He served in this capacity until the end of the war. By mature and practical suggestions an enormous reduction in mortality and morbidity of wounded soldiers ensued. His idea of placing well trained surgeons in the forward area was one of the most important factors contributing to a low mortality rate in World War II. His intimate personal knowledge of the available trained surgeons in the United States was invaluable to the office of the Surgeon General. His idea of shipping whole blood overseas to spots where it was most urgently needed plus the proper management of wounds and early transportation by air of the wounded, resulted in the favorable figures which are reflected in the overall mortality of World War II.

General Rankin's efforts of having specialized centers with specialists in particular fields of surgery available resulted in an almost unbelieveable decrease in neurological and crippling disabilities. A consultant system in surgery was advocated by Doctor Rankin and during the war was the keystone of the arch upon which the brilliant successes of the medical department were builded. His work in this field of administration and surgery during World War II was probably one of Doctor Rankin's best efforts in the field of surgery although his reputation was made as a brilliant abdominal surgeon and most of us know him as such.

Doctor Rankin was honored by receiving the following military citations; World War I Victory Ribbon. World War II: Distinguished Service Medal, Victory Ribbon, E.T.O. Ribbon, Asiatic-Pacific Ribbon, American Theatre Ribbon, Cross of Chevalier of the Legion of Honor.

Fred Rankin was elected President of the American Medical Association in 1941 and took office in June 1942. There immediately devolved upon him one of the greatest tasks that any president of the American Medical Association has had, that of welding the medical manpower of the profession in the United States into a solid body which became cooperative with the Surgeon General's Office and furnished the enormous pool of medical officer manpower needed in World War II. Doctor Rankin guided the American Medical Association in the two first years of World War II in its coordinated effort with the military forces with superior ability.

Doctor Rankin was the author of 300 papers on operative and clinical surgery and the author and co-author of many monographs and text books on surgery of the colon and rectum. His contributions to the field of surgical literature are so enormous as to make it impossible to list them in this sketch but suffice to say that it is the writer's belief that few men on the surgical scene at present have contributed so much to informative surgical literature as did Doctor Rankin.

Doctor Rankin was a member of the Kentucky State Medical Association, the Fayette County Medical Association, Alpha Omega Alpha Honor Medical Society, Phi Beta Kappa, Beta Theta Pi and Sigma Xi. He was a member of the Army and Navy Club in Washington, the Filson Club in Louisville, Kentucky, and the Idle Hour Country Club, Lexington, Kentucky.

Doctor Rankin was honored in many fields, and by many organizations. He was an honorary Fellow of the American Proctologic Society, the Brasilian Proctologic Society and the French Academy of Surgery. In 1915 Saint John's College of Baltimore, Maryland awarded him an A. M. degree. The Doctor of Science degree was awarded him by Davidson College in 1937, University of Maryland 1939, The University of Kentucky 1942, Northwestern University 1943 and the University of Louisville 1947. Temple University awarded him the LL.D. degree in 1943. In May of 1954 he became a Fellow of the Royal College of Surgeons (Edinburgh).

Fred Rankin was a fellow of the following societies: American Surgical Association of which he was president in 1949, the Southern Surgical Association of which he was president in 1937, the Society of Clinical Surgery, the American College of Surgeons of which he served the Board of Governors from 1936 to 1949 and had been a member of the Board of Regents of the College of Surgeons since 1949, and its President in 1954, the Western Surgical Associaiton, the Southeastern Surgical Congress of which he was president in 1938, Southern Medical Association, Visiting Surgeons Club, Interstate Post-Graduate Assembly of which he was president in 1943, the International Society of Surgery, and an honorary member of the Louisville Surgical Society.

Fred Rankin during all of his career in surgery was a diligent worker and active in the dissemination of surgical knowledge. His writings have influenced a whole generation of surgeons. At the beginning of his surgical career he found surgery of the colon in a confused state and due to his pioneer work many operative procedures were both devised and standardized by him. His operation of obstructive resection of the colon was first done in the Louisville General Hospital in 1923 and helped much to reduce mortality in operative surgery on the colon. The Rankin Clamp (1928) for intestinal anastomosis in an aseptic manner revolutionized intestinal surgery, this before the days of antibiotics. His perineo-abdominal resection (1935) of the rectum became a popular procedure for resection in carcinoma of the rectum.

Doctor Fred Wharton Rankin had a part in the formal education of many surgeons all over the United States. Due to his practical and basic surgical contributions, he had influenced surgeons for good, in every part of the world. Wherever the art and science of surgery is practiced one will find the name of Fred Rankin synonymous with enlightened progressive surgery. His students thought of him as an inspiring teacher, his colleagues as a forceful writer, his patients knew him as their benefactor and all honored him as a gifted surgeon.

"Whether the Cup with sweet or bitter run,
The Wine of Life keeps oozing drop by drop,
The leaves of Life keep falling one by one."

D. P. HALL, M. D.
Louisville

THE NEED FOR A SIMPLE TEST FOR EARLY CANCER

With the ever-increasing interest of the medical profession in malignant neoplasms of the human body, it becomes more and more evident that our greatest needs are not now for improved surgical technique in the extirpation of neoplastic growths and not for palliative procedures that will make the cancer sufferers' final years, months or days less painful. The need is for a simple test that can be used almost as a screening procedure for the detection of a malignant neoplasm in the body while it is still in its earliest stage, growing silently in one spot, and has not yet spread to surrounding tissues by the blood stream, lymph stream, or by direct continuity. Carcinoma, in its later stages, when the patient may be filling his body cavities with fluid, and may have metastatic nodules in widespread organs, offers us not much in the way of diagnostic challenge save perhaps "Where is the primary?" In such instances, our efforts can be directed only toward easing the patient's path while he or she clings precariously to life. But if a simple screening procedure could be devised that would make it possible to determine what persons in the population as a whole should be carefully and minutely studied for the presence of a malignancy in some system of their body, with relatively good assurance that a neoplasm was present somewhere in the body, when such a test was positive, medical research would have given to the profession and to humanity a life-saving measure.

The surgeon, who is adequately trained, is no longer confounded by the possibility of curing carcinoma in the vast majority of cases **IF** the growth can be detected **early.** Unfortunately, many of our tumors do not cause pain or discomfort and remain as silent parasites of the human body until they have so firmly established tentacles in the tissues that cure is impossible. Some might reasonably suggest that the person over forty should have a gastrointestinal X-ray examination every six months or certainly every year. This undoubtedly would lead to the detection of a great many carcinomas of the gastrointestinal tract while they can still be completely and totally cured. However, this would place a grave economic responsibility upon the populace and would be beyond the scope of performance of all the radiologists today available, leaving them no time to carry on their other work. Unfortunately, chest plates are not too satisfactory in the detection of early bronchogenic carcinoma. However, they certainly have their place. But there are many technical difficulties that make it impossible for the roentenologist to assure the surgeon that a bronchogenic tumor is present until that tumor has grown beyond the bounds of cure.

Dr. George M. Papanicalaou has given us, after many years of careful study, a procedure that makes possible the detection of malignancies in the examinations of smears from the female generative tract and from secretions from various parts of the body. However, this type of examination or screening burdens the pathologists of the country beyond the limits of their available time, if undertaken on a major scale.

One could wander on at length in this philosophical consideration of the possible approaches to the early detection of carcinoma, but it remains a fact that a simple reliable screening test would greatly widen our horizons and make possible the ferreting out of the early elusive malignant growth.

We already have simple procedures that tell us much about the advanced "carcinoma case," notably albumin-globulin studies, and very simply the red blood cell sedimentation rate. Unfortunately the sedimentation rate is not used by the profession as widely as it might be. The red blood sedimentation rate, properly corrected for the red blood count, is a simple procedure to perform and is done quickly. If within an hour the red blood cells settle through a narrow zone, the patient is probably, to all intents and purposes, in a state of physical well-being. If the settling is an intermediate zone, then we may suspect various, usually chronic, disease processes. But if sedimentation is rapid and marked, then we must suspect a more serious disease process, or a more acute process, or a disseminated carcinoma.

A screening test, to be successful, valuable and useful, should have a high degree of sensitivity. That is, it should be of such a nature that if malignancy in even a few cells or small glands or portion of an organ is present, then the sensi-

tive test will detect that presence. Else, unless it is repeated at very frequent intervals, it will lose its reliability and usefulness. Further, such a screening test should have a very high order of specificity. That is, if a positive result is returned, the physician should have assurance that the patient in question has a malignant neoplasm within some organ or some part of the body. Combinations of sensitivity and specificity are difficult to attain in any test. If we have a test which is not highly specific, we face the possibility of giving men and women who have such a positive test which is, in truth not a true test, a "cancer-phobia." These pitiful persons are seen in every physician's office at one time or another, as they wander about their community, their community being determined by their financial resources, seeking out someone who will assure them that they do have a malignant growth.

Returning to the philosophical approach, it seems that if we were to have a sensitive screening test for the detection of carcinoma, that early neoplastic growths must produce or be attended by a change in the body as a whole, rather than at the site of the primary tumor growth, be that breast, stomach, thyroid, testicle, ovary, uterus, or other organ. When I say change in the body generally, I mean change in the blood, lymph tissue, fluids, or other substance which is common to all parts of the body. Whether such a widespread change does occur or whether tumor growth in a particular organ depends entirely on changes in that organ, remains to be seen. Further mention of this will be made later.

One point which seems to us of interest is the fact that often malignant cells grow rapidly and for this rapid growth, they probably require special foods. Work with folic acid has shown that rapidly growing tumors take great quantities of folic acid and a substance has been synthesized which, when placed in the body of the patient, prevents the tumor cells from using the folic acid and at least for a while slows their growth.

We have recently completed a series of 4019 tests for the detection of carcinoma following the method set out by Dr. Huggins of Chicago. Dr. Huggins' original report on a small group of cases was very enthusiastic and stimulated us to carry out this work. The 4019 tests were done on patients other than tonsillectomy cases and pediatric cases, being routinely admitted to Norton Memorial Infirmary. The work was carried out with the generous cooperation of the board of trustees of Norton Infirmary and through the cooperation of the University of Louisville School fo Medicine.

The first 250 tests that were completed gave us only one false result in so far as we could tell, either a false positive or a false negative. When 500 of the tests were completed, we had a test that seemed to be as reliable as is the Kahn test for syphilis, both from the standpoint of sensitivity and specificity. But when the study was finally terminated, after more than 4000 examinations were completed, we found that our results were of no value either from the standpoint of sensitivity or specificity. It must be borne in mind that time may correct our values for sensitivity, because we are deciding only on the basis of what we can demonstrate with our present means in the diagnosis of carcinoma. In other words, some of the persons in whom we had a positive test, that we have assumed to not have carcinoma, may actually have had an early quiescent carcinoma at the time of the examination, but time alone will provide the answer. A great deal of work is going on over the country in search for such a test. One institution that we have visited is going forward with a battery of ten different tests. Very recent reports from the University of California have indicated that workers there have come up with a test that may prove of value.

Drawing on our experience with the use of the Huggins Test, there is at least one visible ray of hope—A possibility that it may be true that there is a change in some factor of the blood. That it may be possible to devise a successful screening test for the deficiency or oversupply of this substance that accompanies the presence of early tumor growth. This hope stems from the fact that, in the course of carrying out our tests, we were able to change strongly positive tests to equally strongly negative tests by the addition of the scantiest possible amounts of certain of the amino acids. We feel that this indicates something that parallels the finding relative to the folic acid metabolism of tumor cells and that, if the type of procedure we have used can be refined to a point where the testing is not for the rather wide band of change that we were

(Continued on page 553)

President's Page

The scientific program for the September meeting has been completed. While geographical and specialty distribution of essayists have been considered, only good speakers with sound experience have been chosen.

Diagnosis is to be emphasized—especially diagnosis with a minimum of gadgets. Some possible simplification in the choice of laboratory procedures will be explained. Quality of interpretation will be given precedence over quantity of tests employed.

The increasing incidence of malignancy indicates a wider use of biopsy technique and this will be demonstrated in a panel devoted to that subject.

This is the last session at which orations in medicine and surgery are scheduled for presentation. All are urged to give these orators a good audience.

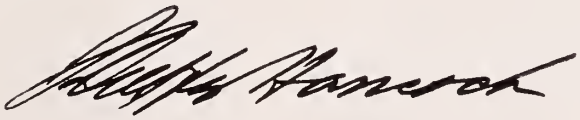
The innovation of having no general session on Wednesday afternoon will be closely observed. Its utilization in future years will be dependent upon the type of acceptance it obtains at this meeting.

It will eliminate one general session. By utilizing the guest speaker of the specialty groups for two papers each, one of which is before a general session, the number of places open for members before the general sessions will be somewhat decreased.

These disadvantages should be outweighed by the privilege of hearing such distinguished guests and by the increased openings for local speakers in the specialty groups—a total number of twenty-five.

It is hoped that over-all attendance will be stimulated and opportunity for increased contacts and fellowships between general practitioners with certain special interests a chance to pursue them more specifically since all members are invited to all meetings.

Mark off September 21, 22 and 23 on your desk calendar. Plan to meet your friends and improve your efficiency at the Annual Meeting.



President

ORGANIZATION SECTION

Scientific Program Completed For Annual Meeting

Plans for the scientific program which will be packed with an abundance of material of interest to all specialties to be presented at the 1954 Annual Meeting have been completed.

J. Duffy Hancock, M.D., Louisville, chairman of the Committee on Scientific Assembly, stated that the program would include eleven nationally recognized guest essayists and twenty-seven state speakers.

"An innovation in the annual September session which has stirred much interest and enthusiasm will be the Wednesday afternoon meeting on September 22. At this time eight state specialty groups will hold scientific meetings simultaneously, featuring one guest speaker and three state speakers," Dr. Hancock said.

Other features of the program include symposia on physical examination and interpretation of X-Ray and a biopsy panel. A tentative arrangement of the 1954 scientific program is printed in full beginning on the opposite page.

Included among the guest speakers are Raymond E. Myers, D.D.S., dean of the University of Louisville School of Dentistry, who will discuss "Socialized Dentistry and Its Relation to Children," and Milton Cobey, M.D., Washington, D. C., guest orthopedic surgeon who will speak on "Low Back Pain and Its Related Conditions, Particularly the Lumbar Disc." Both will address the scientific session Thursday morning, September 23.



Dr. Myers

Dr. Myers received his D.D.S. degree from the University of Louisville School of Dentistry in 1926. In addition to being the dean of the University of Louisville School of Dentistry, he is professor and head of the department of restorative dentistry. Dr. Myers is a past-president of the Louisville District Dental Society, and chairman of the Socio-Economics Committee, American College of Dentists. He is an active member of the Kentucky State Dental Association and the American Dental Association.



Dr. Cobey

At present, Dr. Cobey is professor of Orthopedic Surgery at Georgetown University Medical School, and is in charge of the Orthopedic Service for the Georgetown University-George Washington Services of the D. C. General Hospital for the resident training orthopedic program. He was graduated from Duke University School of Medicine, Durham, North Carolina, in 1934, and received five years of graduate training in his specialty at Johns Hopkins University, Baltimore, Maryland.

Council Sets August 1 Deadline For Award Nominations

All nominations for the KSMA Distinguished Service Medal and the Outstanding General Practitioner Award to be voted and presented at the September Annual Meeting must be submitted on or before August 1, 1954, it was announced by the KSMA Council.

Nominations for the two awards may be made by county medical societies or individual members and should be submitted to the KSMA Headquarters Office, 620 South Third Street, Louisville, Kentucky. Nominations should include clearly stated reasons for the nominee's eligibility.

The Distinguished Service Medal will be awarded on the basis of contribution to organized medicine, community health education, research, teaching, individual medical service and active military service—for all or one or any combination of these points. In 1953 this award was presented posthumously to R. Haynes Barr, M.D., Owensboro, KSMA president.

Winner of the KSMA Outstanding General Practitioner Award will be eligible for the 1954 General Practitioner Award of the American Medical Association. J. I. Greenwell, M.D., New Haven, was the recipient of both these awards last year.

TENTATIVE SCIENTIFIC PROGRAM

* * * *

THE J. W. THOMPSON MEMORIAL MEETING

COLUMBIA AUDITORIUM

* * * *

THE KENTUCKY STATE MEDICAL ASSOCIATION

Louisville, Kentucky **September 21, 22, 23, 1954**

Tuesday, September 21

9:00 Opening Ceremonies

9:30 "Symposium on Physical Examination"
Garnett J. Sweeney, Liberty, Moderator.
Participants in the Symposium are: Lungs, O. O. Miller, Louisville; Heart, Woodford B. Troutman, Louisville; Abdomen, Joseph E. Hamilton, Louisville; Neurology, Ralph J. Angelucci, Lexington, and Ob-Gyn, Anthony Giglia, Jr., Newport.

10:30 Visit the Exhibits

11:00 "Surgical Treatment of Stenotic Valvular Diseases"
Thomas J. E. O'Neill, Philadelphia

11:30 "Why the Urinary Antiseptics Fail"
William Bromme, Detroit

12:00 "Cardiac Pain" (Oration in Medicine)
Robert S. Dyer, Louisville

12:30 Lunch

2:00 "Interpretation of Minimal Laboratory Procedures"
A. J. Miller, Louisville

2:30 "Obstetric Misconceptions"
John Parks, Washington, D. C.

3:00 Visit the Exhibits

3:30 "Psychiatry for the General Practitioner"
James H. Wall, White Plains, N. Y.

4:00 "Biopsy Panel"
B. B. Holt, Ashland, Moderator.
Participants on the Panel are: Skin, George F. McAuliffe, Louisville; Breast, Jacob Mayer, Mayfield; Cervix, Jack C. Blackstone, Owensboro; Rectum, Rufus Alley, Lexington, and Bone Marrow, Everett H. Sanneman, Jr., Louisville.

Wednesday, September 22

9:00 "Allergy in Infancy and Childhood"
Maurice Kaufmann, Lexington

9:30 "Treatment of Hyperthyroidism"
E. Perry McCullagh, Cleveland

10:00 Visit the Exhibits

10:30 "Immunization in Infancy and Childhood"
John C. Peterson, Milwaukee

11:00 "Surgery of Trauma" (Oration in Surgery)
John E. Haynes, Madisonville

12:00 President's Luncheon, Roof Garden, Brown Hotel

There will be no general session Wednesday afternoon. Instead, there will be eight specialty groups holding scientific meetings in the Columbia Auditorium simultaneously. The eight programs will follow the same schedule as the general session with half-hour presentations starting at 2:00 and 2:30 p.m., with a 30-minute intermission to visit exhibits at 3:00 p.m., with two more half-hour presentations starting at 3:30 p.m. Members of the Association will be free to move from one group meeting to another during these Wednesday afternoon sessions.

Kentucky Society of Anesthesiologists

2:00 "Post-Lumbar Puncture Headache"
Robert W. Lykins, Louisville

2:30 "Fluid Replacement Therapy in Surgical Procedures"
Fred M. Williams, Louisville

3:00 Visit the Exhibits

3:30 "Further Experiences with Hypotension During Surgical Procedures"
Curtiss B. Hickcox, Hartford, Connecticut

4:00 "Anesthesia for Pediatric Thoracic Surgery"
Robert P. Bergner, Louisville

Kentucky Chapter, American College of Chest Physicians

2:00 "Common Clinical Manifestations of Fungus Diseases.
Daniel N. Pickar, Louisville

2:30 "Surgery of Heart Other Than Stenotic Valvular Diseases"
Thomas J. E. O'Neill, Philadelphia

3:00 Visit the Exhibits

3:30 "Home and Office Treatment of Pulmonary Tuberculosis"
D. G. Miller, Jr., Morgantown

4:00 "Sanatorium Care of Tuberculosis"
Frank Stewart, Waverly Hills

Kentucky Chapter, American Academy of General Practice

2:00 "Medical Management of the Complicated and Uncomplicated Duodenal Ulcer"
John F. Ganem, Louisville

2:30 "Gout"
Robert L. McClendon, Louisville

3:00 Visit the Exhibits

3:30 "Hernia in Children"
Ralph M. Larsen, Nashville

4:00 "Office Proctology"
Marvin A. Lucas, Louisville

Kentucky Obstetrical and Gynecologic Society

2:00 "Vaginal Hysterectomy"
Samuel S. Gordon, Louisville

2:30 "Present Status of the Rh Factor"
Glenn Bryant, Louisville

3:00 Visit the Exhibits

3:30 "Operative Obstetrics"
John Parks, Washington, D. C.

4:00 "Etiology and Incidence of Foetal Anomalies"
Joseph Spaulding, Paducah

Kentucky Chapter, American Academy of Pediatrics

2:00 "BCG Vaccination"
John C. Peterson, Milwaukee

3:00 Visit the Exhibits

3:30 "Congenital Heart Disease"
Alex J. Steigman, Louisville, Moderator.
Participants are: Samuel Kaplan, Cincinnati; Hugh Lynn, Louisville; I. Diamond, Louisville, and Everett L. Pirkey, Louisville.

American College of Physicians

2:00 "Carbohydrate Metabolism"
James Robert Hendon, Louisville

2:30 "Differential Diagnosis of Pituitary Tumors"
E. Perry McCullagh, Cleveland

3:00 Visit the Exhibits

3:30 "The Mode of Action of Chemotherapeutic and Antibiotic Agents"
Wallace E. Herrell, Lexington

4:00 "Management of the Anuric Patient"
William Brodsky, Louisville

Kentucky Psychiatric Association

2:00 "Follow-up Studies on the Grantham Type Lobotomy"
Louis M. Foltz, Louisville

2:30 "Disturbances of Eating"
James H. Wall, White Plains, N. Y.

3:00 Visit the Exhibits

3:30 "Some Aspects of the New Mental Health Law"
Frank M. Gaines, Louisville

4:00 "Chronic Alcoholic Intoxication, an Experimental Study of the Etiology of Delirium Tremens"
Abraham Wikler, Lexington

Southeastern Surgical Congress

2:00 "The Groin Dissection for Malignancy"
Robert Tate, Louisville

2:30 "To be Announced"
C. Walker Air, Ludlow

3:00 Visit the Exhibits

3:30 "To be announced"
Guest Surgeon

4:00 Surgical Management of Cancer of the Colon and Rectum"
Coleman C. Johnston, Lexington

Thursday, September 23

9:00 "Low Back Pain and Its Related Conditions—Particularly the Lumbar Disc"
Milton Cobey, Washington, D. C.

9:30 "Socialized Dentistry and its Relation to Children"
Raymond E. Myers, D.D.S., Louisville

10:00 Visit the Exhibits

10:30 "Hashimoto's Disease
Ralph M. Larsen, Nashville

11:00 "President's Address"
J. Duffy Hancock, Louisville
KSMA President

11:30 "Installation Ceremony"
(Charge to new members, making of awards, installation, presentation of past-president's key)

11:45 "Plastic Surgery"
John C. Weeter, Louisville

12:15 Lunch

2:00 "Bronchiectosis"
William C. Hambley, Pikeville

2:30 "Recommended Expansion of Interests in Anesthesiology"
Curtiss B. Hickcox, Hartfort, Connecticut

3:00 Visit the Exhibits

3:30 "To be announced"
Guest Surgeon

4:00 "Symposium on X-Ray Interpretation"
Robert M. Coleman, Hopkinsville, Moderator.
Participants are: Abdomen, Edward Maxwell, Louisville; Skeleton System, Leslie Urban, Ashland, and Chest, Thomas P. Leonard, Frankfort.

Dr. Griswold To Head Kentucky Surgical Society

R. Arnold Griswold, M.D., Louisville, former head of the Department of Surgery at the University of Louisville School of Medicine, was elected president of the Kentucky Surgical Society at the Fifth Annual Meeting held at French Lick, Indiana, May 15, 1954. He succeeds W. Vinson Pierce, M.D., Covington.



Dr. Griswold

Approximately 150 members of the association and their guests attended the meeting. William H. Pennington, M.D., Lexington, was elected vice-president, Francis Massie, M.D., Lexington, was elected secretary-treasurer for a three year term at the meeting last year.

Featured guest speaker was I. Mims Gage, M.D., professor of clinical surgery at Tulane University of Louisiana School of Medicine, New Orleans. The title of his scientific discussion was "Chronic Relapsing Pancreatitis."

Charles A. Vance, M.D., Lexington, chairman of the KSMA McDowell Committee, reported to the Kentucky Surgical Society on the activities of the McDowell Home. The society contributed $1,000 toward the support of the McDowell Home last year.

At the meeting the society voted to increase its membership limit from 100 to 125. The added members will be received in 1955. The location of next year's meeting will be determined by members of the Council at a later date.

Ky. Chapter of ACS to Hold 1st Meeting, Sept. 20, Louisville

The first regular scientific and business sessions of the newly organized Kentucky Chapter of the American College of Surgeons will be held in Louisville, on September 20, 1954, according to James Drye, M.D., Louisville, secretary.

Features of this meeting will include a luncheon, outstanding nationally known surgical speakers, election of officers, formation of policies and appointment of committees, Dr. Drye stated.

Fellows of the ACS, meeting in Louisville on September 21, 1953, voted unanimously to organize the Kentucky Chapter. At that time H. Prather Saunders, M.D., associate director of the American College of Surgeons, addressed the group and explained the operation of other local chapters which had been previously organized.

M. J. Henry, M.D., Louisville, was elected president, Francis Massie, M.D., Lexington, vice president, and Dr. Drye, secretary-treasurer. Clyde C. Sparks, M.D., Ashland, E. W. Jackson, M.D., Paducah, and Edward Mersch, M.D., Covington, were elected to the office of councilor.

M.D.s Secretaries Attend PR Courses in Two Counties

Physicians' assistants in Daviess and Henderson counties in May and June attended public relations courses especially prepared for them by their county medical societies in cooperation with the KSMA Education Campaign Committee.

Attendance averaged 30 in Daviess county where meetings were held in Owensboro, May 18, 25 and June 1. In Henderson county approximately 20 attended sessions May 17, 24 and June 2.

This public relations course, developed by the Education Campaign Committee to bring helpful public relations techniques into the offices of busy physicians, is available for county medical society sponsorship on request to the KSMA Headquarters Office. There is no charge for the instruction.

Dr. Overstreet Is New Governor For Kentucky ACP

The position of Governor for Kentucky of the American College of Physicians was recently filled by Sam Overstreet, M.D., Louisville, after the vacancy was created on the Board of Governors by the election of J. Murray Kinsman M.D., Louisville, to the Board of Regents of the American College of Physicians.

Dr. Kinsman, governor of the Kentucky members for the past six years, was elected to the Board of Regents, an office of high honor, at the spring meeting of the American College of Physicians in Chicago. Under the governorship of Dr. Kinsman there has been a substantial increase in membership in the Kentucky chapter.

Members of the group in Kentucky are one of the eight specialty groups to bring outstanding guest speakers to participate in the scientific program of the Annual Meeting of the KSMA, September 21-23, in Louisville. E. Perry McCullagh, M.D., Cleveland, Ohio, has been invited by the chapter to address both the 91-member specialty group and also the general scientific session.

Senior U. of L. Medical Students Hear Dr. Clyde Sparks

Various aspects of medicine and methods of handling problems encountered by practicing physicians today were informally discussed with the graduating class of the University of Louisville School of Medicine by Clyde C. Sparks, M.D., president-elect of the KSMA, on May 13, 1954, at Louisville General Hospital.

He recommended to the members of the class that they realize the value of consultation in both scientific and management problems as a way of strengthening position in a community. By seeking consultation with a respected physician, either at the request of a patient or by acting on his own initiative, a young doctor can assure his patients he is genuinely interested in their welfare, Dr. Sparks said.

A warning was made against the unfortunate results of assuming a Messiah complex at any time. He pointed out that such a physician may fool a fair portion of the public for awhile, but his clientele will not remain stable and the physician is often reduced to practicing "drawing room medicine."

Dr. Sparks encouraged the class to support hospital expansion particularly in the chronic disease field and to support the keeping of hospital expenses to patients at a minimum. In helping to arrive at decisions he urged that they keep in mind that hospitals are institutions in which medicine is to be practiced and not institutions to practice medicine.

When seeking a suitable location, Dr. Sparks advised each to consider first of all whether there existed an actual need for another physician in the community. Health insurance, medical care for veterans, medical ethics and the principle of free-choice-of-physician were also explained.

Scott County Pays Tribute to Three Former Presidents

The Scott County Medical Society recently paid tribute to three former society presidents, E. C. Barlow, M.D., L. F. Heath, M.D., and W. S. Allphin, M.D., of Georgetown, all of whom have rendered a lifetime of service to their community for the past fifty years or more, according to H. V. Johnson, M.D., Georgetown, secretary of the society.

Dr. Barlow, a graduate of the Cincinnati Medical School of Ohio State University in 1901, has always been an advocate of preventive medicine. He is a former health officer of Georgetown and a present member of the county health board and active in the practice of his specialty, eye, ear, nose and throat. Dr. Barlow is also active in church and civic affairs.

Before opening his office in Georgetown in 1914, Dr. Heath practiced in Minorsville, Newton, and Lexington. He has practiced in Georgetown for forty consecutive years, and always been a member of the Kentucky State Medical Association. He is a deacon in the Christian Church and has taken an active part in church affairs.



Highlight of the Annual Session of the Kentucky Surgical Society is the Annual Dinner, this year held May 15, at French Lick, Indiana. At the Speakers Table seated from left to right are: Mrs. Charles A. Vance, Lexington; W. Vinson Pierce, M.D., Covington, retiring president of the society; Mrs. R. Arnold Griswold, Louisville; I. Mims Gage, M.D., New Orleans; Mrs. W. Vincent Pierce, Covington; R. Arnold Griswold, M.D., Louisville, president, Mrs. I. Mims Gage, New Orleans, and Charles A. Vance, M.D., Lexington.

Dr. Allphin was graduated from the Louisville Hospital College of Medicine in 1904, and has been engaged in the practice of medicine in Georgetown since 1925. He has always taken an active interest in civic affairs, especially the Boy Scouts. At the present he is president of the First National Bank, a deacon in the Baptist Church, and a member of the Scott County Board of Health.

Queries on Officers' Conference Answered by 62 Per Cent

Circulation of an Opinion Survey to those attending the Fourth Annual Officers' Conference, Lexington, April 15, resulted in some interesting answers from the 62 per cent who returned the questionnaires during a two-week period.

"How Best to Promote the Idea of a Family Physician for Every Family" and "Headquarters Office Helps to County Medical Societies" proved the two most popular topics suggested for future discussion. In addition, 72 per cent made suggestions of their own. These will be of help to next year's Conference committee members who will use them as program guides.

All agreed that the Conference should be continued. Almost as unanimous was the opinion that the Conference had proved helpful. The 1955 Conference will be held in Lexington.

Dr. Daniel Elkin Receives Award For Distinguished Service

The many friends of Daniel Collier Elkin, M.D., who is a native Kentuckian, will be glad to know that he received the Lamartine Griffin Hardman Award for distinguished service to medicine and the medical profession in Georgia and for exceptional work in the field of vascular surgery.

Dr. Elkin, who has been professor of surgery and chairman of the department of Emory University School of Medicine for the past 24 years, received the award during the 104th Annual Session of the Medical Association of Georgia, in Macon on May 5. He will retire from the faculty at the end of the academic year.

In 1940, Dr. Elkin was the third man to receive the Matas Medal from Tulane University for achievements in advancing the progress of vascular surgery. For valuable service rendered during World War II in the medical corps of the U. S. Army, Dr. Elkin was awarded the Legion of Merit. He holds the rank of Brigadier General. His plans for the future call for retirement to a blue grass farm in Kentucky on which he spent the early part of his life.

KPHA Elects Raymond Dixon President-Elect

Raymond F. Dixon, Louisville, deputy state health commissioner in charge of administrative services, was elected president-elect of the Kentucky Public Health Association at the annual meeting in Louisville May 19-21. Mr. Dixon will succeed Miss Mary A. Gallagher, La Grange, next year.

Bruce Underwood, M.D., Louisville, state health commissioner and secretary and general manager of the Kentucky State Medical Association, told the association an evaluation program is being formed which will set up minimum standards for local health departments. Such a program is intended to raise the health standards in all Kentucky counties.

The commissioner indicated that he hoped to have a health officer or well-trained administrator in every county in the near future. Dr. Underwood cited several new bills passed by the Kentucky General Assembly to strengthen local health departments. One of these allows citizens of the county to authorize a special tax for public-health purposes, he said.

President of the Kentucky State Medical Association, J. Duffy Hancock, M.D., Louisville, in speaking to the group indicated his belief that the public needs more information about health programs since they are subject to misconceptions if told too little.

Other new officers elected by the KPHA are Rodney Quiller, Louisville, hospital inspector in the State Department's Division of Hospital Services, vice-president; and Orman R. Wright, Jr., Louisville, administrative assistant to the State Health Commissioner, secretary.

Dr. Hancock and Symposium to Be Featured by Districts 12, 15

A presidential address and a Symposium on Cardiovascular Diseases will be major points of interest to physicians and their wives attending a joint meeting of the Twelfth and Fifteenth Councilor Districts at DuPont Lodge, Cumberland Falls, July 15.

According to Garnett Sweeney, M.D., Liberty, councilor for the twelfth district, and Edward Wilson, M.D., Pineville, councilor for



Marion F. Beard, M.D., Louisville, (second from left) was elected chairman of the Nominating Committee of the KSMA at a meeting April 15, at the Phoenix Hotel, Lexington, during the Fourth Annual County Society Officers' Conference. Other members of the committee (seated from left to right)) are John S. Harter, M.D., Louisville; Carl Fortune, M.D., Lexington, and T. O. Meredith, M.D., Harrodsburg. Howell Davis, M.D., Owensboro, also a committee member, was not present.

the fifteenth district, who made the joint announcement, J. Duffy Hancock, M.D., Louisville, KSMA president, will be the featured guest dinner speaker. He will discuss "KSMA Services." Another highlight of the evening program will be a talk on "Veterans Medical Care Program" by David Cox, M.D., Louisville, president of the Jefferson County Medical Society.

Participants of the Symposium which begins at 3:30 p.m. (EST), are George W. Pedigo, M.D., Louisville, who will discuss "Medical Management of Acute Myocardial Infarction," Ralph Denham, M.D., Louisville, whose topic is "Digitalis and Digitalis Intoxication," and W. Burford Davis, M.D., who will speak on "Surgery in Management of Mitral Valve Disease." Two hours credit will be allowed by the Academy of General Practice.

District 7 Elects Officers June 2, Attendance Totals 74

Willis P. McKee, M.D., Eminence, was elected president of the Seventh Councilor District at the business session following the annual dinner meeting at the Frankfort Country Club, June 2, it was announced by B. B. Baughman, M.D., councilor.

Seventy-four members, wives and guests were present with representation from nine of the ten counties which compose the district, Dr. Baughman said. Other officers elected were Paul Harrison, M.D., Owenton, vice-president, and Lenore Chipman, M.D., Williamstown, secretary.

Featured guest dinner speaker was J. Duffy Hancock, M.D., Louisville, president of the KSMA, whose address was entitled, "KSMA Services." Members of the Franklin County Medical Society, of which Edward K. Martin, M.D., Frankfort, is president, acted as hosts.

At the scientific session following the dinner meeting, J. Park Biehl, M.D., Cincinnati; Thomas B. Leonard, M.D., Frankfort, and Dr. McKee presented scientific discussions. Livingston A. Wahle, M.D., Shelbyville, retiring district president, presided.

Students and Science Profit From Medical Research Scholarships

Ever increasing interest is being shown in the University of Louisville School of Medicine's Student Research Scholarships, a program which was begun more than 20 years ago, according to Peter K. Knoefel, M.D., secretary of the Research Committee.

Through such an activity the medical student is offered what may be his only opportunity for actual experience in research, which will be the source of advances made after graduation with which he must become familiar by his own efforts. The program has also served to recruit men for careers in medical research, and to provide assistance in research programs in progress in the school.

Applicants for these scholarships have always exceeded the number offered which must operate in accordance with financial support received. Recently, because of growing interest, augmented funds have been obtained for thirteen scholarships.

University of Louisville medical students who have received these scholarships are : J. R. Almand, Berlin, New Hampshire; J. L. Alexander, Anchorage; Wendell W. Burns, Bowling Green; Everett Coleman, McAndrews; Clyde Danks, Beaver Dam; William A. Johnson, Elizabethtown; E. Khouri, Louisville; T. R. Mar-

shall, Charlestown, Indiana; Ronald Naser, Sturgis; James Ross, Lexington; G. R. Schrodt, Louisville; Charles C. Smith, Fonde and Virginia Stevens, Baxter.

In the Department of Anatomy a research project to determine the effect of a plant sterol on experimental arteriosclerosis was made possible through one of the four scholarships offered by the Commonwealth Life Insurance Company. It has been found that the oral administration of a plant sterol, "Sitosterol," reduces the blood cholesterol in man. Rabbits were fed a diet to which cholesterol was added; a similar diet to which an equal amount of "Sitosterol" was added was fed a second similar group of rabbits. At the end of forty days the arteries of both groups were studied. Comparison of the arteries of the two groups showed somewhat more arteriosclerosis in the group fed cholesterol alone.

Other scholarships are being offered by the Kentucky Division of the American Cancer Society, the Farrar Fund for Cancer Research, the Kentucky Heart Association, Baxter Laboratories, Inc., Morton Grove, Illinois, the Hert Fund for Medical Research, the Fawcett-Dearing Printing Company, and the Louisville Rotary Club.

U. K. Board of Trustees Approves Medical School Establishment

The University of Kentucky's Board of Trustees on June 1, 1954, formally approved establishment of a grade-A medical school in Lexington with the over-all plan envisioned to cost approximately $25,000,000, according to published reports. The university will request funds for the project from the Kentucky General Assembly.

In March, 1954, a seven man committee composed of physicians and civic leaders formed the Kentucky Medical Sciences Development Foundation to promote interest in the new medical school.

Immediate objectives of the foundation since the action taken by the Board of Trustees are to file articles of incorporation, appoint a dean and formulate building plans tentatively for July 1955. Another function of the foundation is to receive tax-exempt funds from private sources.

Included in the $25,000,000 plan are a 600-bed hospital costing $10,000,000; medical-sciences building, $4,500,000; and also clinics, offices, laboratories, out-patient department, library, schools of dentistry and pharmacy, and residence halls. A $6,000,000 endowment for 18 chairs of medicine at $10,000 each would also be provided for and not included in the $25,000,000.

Ky. AAGP to Hold Seminar at Ky. Lake, July 22

The Kentucky Chapter of the American Academy of General Practice will hold a seminar at the Kenlake Hotel in Kentucky Lake State Park, July 22, according to Charles Baron, M.D., Covington, chairman of the Educational Committee.

Guest speakers include: Robert Greenblatt, M.D., University of Georgia School of Medicine, "Functional Uterine Bleeding;" Albert Weinstein, M.D., Vanderbilt University School of Medicine, "Peptic Ulcer;"

F. S. Hill, M.D., University of Tennessee College of Medicine, "Problems in Pediatrics;" Morton Hamburger, M.D., University of Cincinnati College of Medicine, "Recent Advances in Antibiotic Therapy," and Daniel Jones, M.D., University of Cincinnati College of Medicine, "Advances in Pediatrics."

Plans Drawn for Diabetes Drive In Nov. by KSMA Committee

The 1954 state-wide Diabetes Detection Drive, sponsored by the KSMA in cooperation with the American Diabetes Association, will be held November 14-20, according to Carlisle Morse, M.D., Louisville, chairman of the KSMA Diabetes Committee.

At a meeting of the committee in Louisville, May 27, preliminary plans were discussed regarding the drive's effectiveness. It was agreed that it is important that county chairmen begin their plans early. Cited as an example was the fact that effective planning with schools calls for action as early as August.

A report was presented comparing the results of the 1953 Diabetes Detection Drive in Kentucky with the one held in 1952. This showed that the number of urine sugars performed increased from 30,934 to 35,384; the number of positive urines found increased from 564 to 595, and the number proved diabetic increased from 182 to 228.

Criteria Changed for Usage of GG for Poliomyelitis

Attention, all Kentucky physicians: the criteria for the usage of poliomyelitis immune globulin has been changed in accordance with results determined by a recent study conducted by the National Advisory Committee for the Evaluation of Gamma Globulin, it has been announced by U. Pentti Kokko, M.D., act-

ing director of the Division of Preventive Medicine, Kentucky State Department of Health.

In the future, the usage of gamma globulin for poliomyelitis prophylaxis in Kentucky will be based on the following criteria: (1) that poliomyelitis immune globulin be used for inoculations in groups larger than a single family unit, (2) that the State Department of Health determine those to constitute a group, the time and the area for the group inoculation, (3) that eligible individuals be used 16 years of age or pregnant women and that dosage consist of 0.2 pound of body weight, not to exceed 15 cc per person, (4) that gamma globulin for this purpose be used in such a way as not to affect the validity of the vaccine field trial.

Record Number of Physicians Licensed in 1953

An all-time record number of physicians—218,522—were licensed to practice medicine in the U. S. at the close of 1953, it was disclosed in the 52nd annual report on medical licensure of the AMA's Council on Medical Education and Hospitals.

Of this number, a total of 2330 physicians were licensed in Kentucky during 1953. During this year 127 new licenses were issued, in 1952 there were 214 added.

Of the total number of licensed physicians in the U. S., 156,333 were engaged in private practice, 6,677 were engaged in research, teaching or were employed by insurance companies, industries and health departments, 29,161 were interns, residents and those engaged in hospital administration.

The report disclosed that 17,040 physicians were in government service last year and that a total of 7,276 received their first license to practice medicine.

Dr. Norvell Projects Community Service In Henry County

Something new in community service, successfully projected in Henry County by a member of the Kentucky State Medical Association, has attracted the attention of the Louisville Courier-Journal and the Progressive Farmer, a large farm magazine with distribution throughout the South.

"Stewardship Sunday Movement", the idea of the K.S.M.A. Vice President and Chairman of the K.S.M.A. Rural Health Committee, Wyatt Norvell, M.D., New Castle, has received generous space in both publications.

According to Paul Hughes, Courier-Journal Staff Writer, in the Sunday May 23 issue, "The doctor, the minister, the lawyer and the land expert gave their ideas of accountability in making the best use of the human body, of religion, of the family and the life giving soil of the earth."

Mr. Hughes was referring to a meeting he had attended the Sunday before at a New Castle church. The movement started two years ago and similar meetings have been held in numerous Henry County churches since, the Courier article reported.

"Live" Broadcast of AMA Meeting Carried Coast-to-Coast

A "live" report from San Francisco on scientific highlights of the 103rd Annual AMA Meeting in June, sponsored by Smith, Kline, and French Laboratories in cooperation with the American Medical Association, was carried on a coast-to-coast radio and TV broadcast.

After taking his oath of office as 108th president of the AMA on June 22, Walter B. Martin, M.D., Norfolk, Virginia, delivered his inaugural address containing important information on th activities of the medical profession.

By "eavesdropping" on an official meeting of the AMA's House of Delegates, the nation learned how America's physicians run their national organization. Stations in Ashland, Bowling Green, Lexington and Louisville carried the program.

Also featured were Edward J. McCormick, M.D., Toledo, Ohio, retiring AMA president; Dwight H. Murray, M.D., Napa, California, chairman of the Board of Trustees and James Rueling, M.D., Bayside, New York, speaker of the House of Delegates.

Federal Scholarships

The Student American Medical Association at its recent convention in Chicago, voted to take no action on a program of federal scholarships wherein a medical student would agree to service in the armed forces for each year he received federal aid, according to William P. Vonderhaar, Louisville, delegate from the University of Louisville School of Medicine's chapter at the convention.

A committee was appointed to study the aspects of a program in which scholarships would be awarded on the basis of the number of students in a class instead of following the outlined program that 300 scholarships be awarded each year with 100 allotted to each branch of the service.

KSARN Bulletin Wins Award

An award for showing the greatest improvement over a twelve month period was presented to the "New Letter," a publication of the Kentucky State Association of Registered Nurses edited by Cynthia N. Warren, Louisville.

The award was presented by the American Journal of Nursing Company at a meeting of the editors of the thirteen State Nurses Association Bulletins in Chicago, May 1. All state associations were given equal opportunity to win one of several awards offered.

Graduates of 1904 Hold Reunion

A group of twenty physicians who graduated in 1904 from various medical schools in Kentucky which existed before the formation of the present University of Louisville School of Medicine held a reunion in Louisville on May 7, 1954.

Average age of the 50-year old graduates was estimated to be 75. Most of the physicians were from Kentucky or surrounding states. Oldest graduate in the group was J. T. Kessinger, M.D., a native of Grayson County, who was 87 and now lives in Wood River, Illinois.

Canada Host to Industrial Group

The International Association of Industrial Accident Boards and Commissions will hold its next annual convention at the Chateau Frontenac, Quebec, Canada, October 3-7, according to Carl M. Peterson, M.D., secretary of the AMA Council on Industrial Health.

As has been the custom in recent years, a large part of the program will be devoted to the medical problems of workmen's compensation, although other aspects of the program include legislation and other fields of compensation.

FCDA Prepares for Emergencies

As part of its emergency medical supply stockpiling program, Federal Civil Defense Administration has ordered 200 portable hospital units of 200-bed capacity, and another 90 are on order for states and cities under the matching program wherein the state and the federal government share the cost.

Patterned after the mobile Army surgical hospital unit, the FCDA hospital is designed to provide early hospitalization of seriously ill and injured as close as possible to a stricken area. Each unit costs $26,435.47.

Is Your Class Having a Reunion?

If you graduated from the University of Louisville School of Medicine in 1909, 1914, 1924, 1934, 1944 or 1949, you can look forward to being reunited with many of your former classmates at Annual Meeting time.

Each of these six classes will hold a special reunion highlighting the activities of the Annual Meeting of the Kentucky State Medical Association to be held in Louisville, September 21, 22, and 23.

In a previous issue of the Journal, four of these reunions were announced. According to Leslie Shively, director of Alumni Relations for the University of Louisville, two additional reunions—the classes of 1909 and 1949 also will be held. Consult the August issue of the Journal of the KSMA for further details.

AHA Offers Research Scholarships

Applications for research awards for studies beginning July 1, 1955, are now being accepted by the American Heart Association, according to Robert A. Thornbury of the Kentucky Heart Association.

Complete information and forms may be obtained from the Medical Director, American Heart Association, 44 East 23rd Street, New York 10, N. Y. Applications for Research Fellowships, awarded for one or two year periods and Established Investigatorships, awarded for one to five year periods, may be filed up to September 15, 1954.

Research grants-in-aid applications awarded for periods of one to three years will be accepted up to December 1, 1954. Funds to support the research program are provided by the 1954 Heart Fund Campaign conducted by the AHA and its affiliated associations and chapters.

District 6 Meets June 8

Highlight of the Sixth Councilor District Meeting of the KSMA June 8, at the Helm Hotel, Bowling Green, was the scientific session, featuring Henry Harris, M.D., and Frank Moore, M.D., of Bowling Green, according to Richard F. Grise, M.D., secretary of the district.

Dr. Harris's paper was entitled "Urinary Tract Stones" followed by Dr. Moore's discussion of "Experience with Use of Diamox." J. Duffy Hancock, M.D., Louisville, KSMA president, was a featured guest speaker. The Warren-Edmonson County Medical Society was the host group. Walter Byrne, M.D., Russellville, presided over the business session.

District 9 to Meet July 8

Featured guest speaker, J. Duffy Hancock, M.D., Louisville, KSMA president, and an outstanding scientific program will highlight the annual dinner meeting of the Ninth Councilor District, July 22, at the Maysville Country Club, it has been announced by J. M. Stevenson, M.D. Brooksville, councilor.

"Common Sense in Diagnosis and Treament of Anemia" is the subject that Franklin B. Moosnick, M.D., Lexington, will discuss as a part of the special scientific program. In addition, Robert F. Monroe, M.D., Louisville, will talk on "Pelvic Tumors Complicating Delivery," as the final presentation of the session.

For those physicians and their wives who would like to play golf in the afternoon before the meeting, the recreational facilities of the Maysville Country Club are available.

Fayette County Hears Dr. Gage

I. Mims Gage, M.D., New Orleans, professor of clinical surgery at Tulane University of Louisiana School of Medicine, was the featured guest speaker at the annual dinner meeting of the Fayette County Medical Society, held May 13, at the Lafayette Hotel in Lexington, according to Rankin Blount, M.D., president of the society.

"Malignant Melanoma" was the topic of Dr. Gage's discussion. Approximately 250 members of the society and their guests attended the annual meeting.

District 4 Hears Dr. Hancock

J. Duffy Hancock, M.D., Louisville, KSMA president, was the featured speaker at the dinner meeting of the Fourth Councilor District June 9, at Hardin Memorial Hospital, Elizabethtown, according to W. Keith Crume, M.D., Bardstown, councilor. He discussed "KSMA Services."

Approximately 50 physicians and their wives attended the district meeting. On the scientific program Alex J. Steigman, M.D., head of the department of pediatrics at the University of Louisville School of Medicine, and James Bruce, M.D., Louisville, professor of pediatrics, were featured speakers.

Laboratory Moved to Health Dept.

The Public Service Laboratories, University of Kentucky, Lexington, will be officially transferred to the Division of Public Health Laboratories, Kentucky State Department of Health, July 1, 1954. This branch laboratory will be located at the Fayette County Health Department, 212 North Upper Street, and will be known as the Public Health Laboratories—Lexington Branch.

Dr. Arestad Leaving AMA

Fritjof H. Arestad, M.D., associate secretary of the AMA Council on Medical Education and Hospitals, recently resigned from his position to accept an appointment with the United Mine Workers' of America's Welfare and Retirement Fund. Dr. Arestad, who has made several visits to Kentucky for the AMA, will assume his new duties as medical administrator of the Johnstown, Pennsylvania, area on July 1, 1954.

New KSMA Members Total 21

During the month of May twenty-one new names were added to the KSMA membership roster. To each of these the association extends welcoming greetings. The new members are:

Jesse B. Bell, M.D., Waverly Hills,
Edgar T. Dennis, M.D., Louisville,
Z. S. Gierlach, M.D., Louisville,
Harold B. Graves, M.D., Louisville,
James F. Halley, M.D., Louisville,
Gerald Hart, M.D., Louisville,
J. F. Heinrich, M.D., London,
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Roy McKee, M.D., Winchester,
Reginald C. Neblett, M.D., Owensboro,
Naven M. Olsen, M.D., Louisville,
Maurice F. Rabb, M.D., Louisville,
Johnny G. Reynolds, M.D., Winchester,
John H. Walls, M.D., Louisville,
George P. Wyman, M.D., Lakeland,
T. D. Yocum, M.D., Lexington,
Coleman M. Young, M.D., Louisville.

Washington News Digest

Washington, D. C.—The controversial health reinsurance issue has come back into prominence, and under conditions that make the whole question about as complicated as it can get. The bill would have the federal government underwrite voluntary health insurance plans if they agree to experiment with risks not usually covered.

Although this measure is a major part of President Eisenhower's health program, it became bogged down in the House Interstate and Foreign Commerce Committee when widespread opposition developed. Then the committee chairman, Rep. Charles E. Wolverton (R.-N.J.), turned to one of his favorite subjects, a plan for federal guarantee of private loans to health facilities for construction and equipment. This bill, however, was not supported by the administration.

In an effort to placate the opposition, Mr. Wolverton offered to eliminate a number of objectionable features from the mortgage guarantee bill. At the same time there were reports that he proposed to merge this bill with the administration-supported reinsurance bill. Meanwhile, Henry J. Kaiser made two special trips to Washington to help out his friend, Mr. Wolverton, by putting his weight behind the mortgage loan idea. That was not surprising, inasmuch as Mr. Kaiser had helped to draw up the bill, which would greatly benefit health centers such as those started on the West Coast by the Kaiser Foundation.

Mr. Kaiser, saying he was producing a film to promote the mortgage loan plan, went to the unusual extent of making a direct appeal to Washington news correspondents to write favorable copy about the bill.

While these Wolverton-Kaiser maneuverings were taking place on the mortgage bill, it became apparent that President Eisenhower was not ready to abandon the reinsurance idea. He called a number of executives of major life insurance companies to the White House to try to impress them with the merits of reinsurance and in other ways indicated he still wanted to see the bill passed this session. Secretary Hobby, whose original testimony for reinsurance had been restrained, also joined in the last-minute campaign. But it appeared the tangle might be too complicated even for Mr. Eisenhower to unravel before adjournment.

Most other parts of the Eisenhower health program were moving through Congress, even though some were off schedule. (Of the major bills, AMA opposes only reinsurance.) Legislation to expand the Hill-Burton hospital construction program cleared what might have been a serious obstacle when it was reported out by the Senate committee. Compared with the House bill, the Senate bill gave more discretion to state health authorities in use of funds for constructing facilities for the chronically ill, for nursing homes, and for health centers. However, the Senate would require that funds earmarked for rehabilitation centers be used for the stated purpose. The Senate also would rule out the possibility of U. S. grants to centers devoted solely to treatment. Unless the facility could qualify as a diagnostic center, or a diagnositc treatment center, it could not be eligible under the Senate bill. This safeguard was not in the House bill.

Of the remaining legislation of interest to the medical profession, the status at this writing was about as follows:

The doctor draft amendment, to strengthen Defense Department's hand in dealing with physicians who might be security risks, had passed the Senate, been reported by the House committee, and was almost a law. Also about to be enacted was a provision liberalizing medical expense deductions from taxable income. The long-dormant bill to transfer responsibility for Indians' health matters from the Indian Bureau in Interior Department to Public Health Service in the Department of Health, Education, and Welfare was pointed toward enactment, but might possibly be held up by objections of Senators from a few western states. The Interior Department had dropped its original objection.

The House-passed social security bill, with the compulsory coverage of physicians eliminated, was before the Senate Finance Committee, where anything could happen. Two bills of medical interest already had been passed by both houses and signed into law. One prohibits the shipment of fireworks into a state where fireworks are illegal, and the other relieves Army medical officers of the technical responsibility for supervising preparation of food.

A reassuring note was sounded by President Eisenhower when he forwarded to Congress the controversial International Labor Organization convention on minimum standards of social security with a recommendation that it not be ratified. His message said most of the points—including a suggestion for socialized medicine—were not proper subjects for the Congress to deal with.

BUYERS' GUIDE

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Pertinent Paragraphs

The 19th annual congress of the U. S. and Canadian sections of the International College of Surgeons will be held in Chicago at the Palmer House, September 7-10, with advance registration, business meetings, and a meeting of the Woman's Auxiliary on September 6, 1954. For further information, contact your KSMA Headquarters Office.

The 1954 Annual Convention of the National Society for Crippled Children and Adults will be held November 3-5, 1954, at the Hotel Statler, Boston, Massachusetts. The 31st convention will bring together authorities in all the fields of work relating to rehabilitation of crippled children and adults. For more complete information, contact your KSMA Headquarters Office.

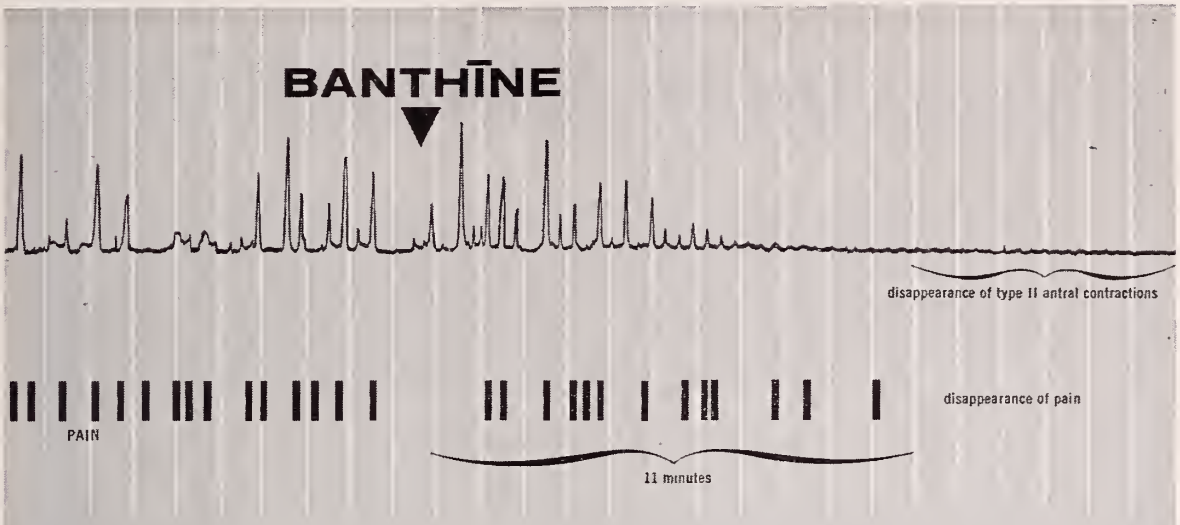
Encouraging developments in the increasing availability of insurance coverage widely known as "major medical and hospital expense insurance" now protects more than one million persons and the number is rapidly growing stated Edward J. McCormick, M.D., Toledo, Ohio, AMA retiring president, in a recent issue of the AMA Journal.

John Fuller Taylor, M.D., professor of biochemistry at the University of Louisville School of Medicine, has been awarded a $5,775 grant for heart disease research by the American Heart Association. The grant is one of 169 made this year by the association. Dr. Taylor will investigate the chemical composition of parts of the heart muscle.

A new radio transcription series, "Thirty-five—Mid-point of Life!", is available in July for distribution to state and county medical societies for airing over local radio stations. Prepared by the AMA's Bureau of Health Education, this series of 13 programs stresses a different area of concern for those who have reached this age.

The Department of Otolaryngology, University of Illinois College of Medicine, will hold its Annual Assembly from September 6-11, 1954. The entire week will be devoted to surgical anatomy and cadaver dissection of the head and neck, and histopathology of the ear, nose and throat. For further details, contact your KSMA Headquarters Office.

(Continued on page 546)



Effect of 100 mg. of Banthīne administered orally on antral gastric motility and duodenal ulcer pain.[2]

Hightower, N. C., Jr., and Gambill, E. E.: Gastroenterology 23:244 (Feb.) 1953

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Ruffin, J. M.; Texter, E. C., Jr.; Carter, D. D., and Baylin, G. J.: J.A.M.A. 153:1159 (Nov. 28) 1953.

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PERTINENT PARAGRAPHS

(Continued from page 544)

KSMA members interested in Civil Defense may wish to request two booklets on the subject available from the AMA's Council on National Emergency Medical Service. The first is a valuable sourcebook entitled, "Proceedings of the Medical Civil Defense Conference" which was held in Louisville in February. The second booklet contains a series of six articles reprinted from the AMA Journal and depicts the role of the physician in civil defense activities.

Breathing exercises which teach heavy smokers proper breathing may help in breaking the habit, according to William Kaufman, M.D., Bridgeport, Connecticut, whose article on the subject was recently published in the Journal of the AMA. He wrote that the reason heavy smokers feel uneasy when they try to give up smoking is that they do not breathe properly. This results in an uncomfortable sense of breathlessness and pressure on the chest, and may cause the individual to become tense and restless.

News Items

Richard B. Jarvis, M.D., Louisville, assistant state commissioner of mental health and director of professional services, in June took a new position as psychiatric consultant in a delinquency-control program in the Seattle, Washington Department of Public Instructions. He had been with the department of mental health since it was created in 1952.

B. F. Radmacher, M.D., Louisville, will resume his practice of internal medicine after serving 26 months in the Navy as a lieutenant in the Medical Corps. Dr. Radmacher was graduated from the University of Louisville School of Medicine in 1944 and interned at the United States Naval Hospital at Great Lakes, Illinois.

J. Kenneth Harris, M.D., recently became associated with **Selby Love, M.D.,** Louisville, for the practice of pediatrics after returning from the service. A graduate of Emory University School of Medicine in Georgia, Dr. Harris received training in pediatrics at Children's Hospital, Louisville.

John F. Rypstra, M.D., after returning from the service in May, has resumed his practice in Annville in Jackson County. Dr. Rypstra is a 1947 graduate of Indiana University School of Medicine, Bloomington, Indiana.

James B. Stith, M.D., will resume his practice of obstetrics and gynecology in Lexington on August 1, 1954, after his release from active duty with the United States Navy, July 31. Since November, 1952, Dr. Stith has served as Assistant Chief of Dependents Service, Department of Obstetrics and Gynecology, U. S. Naval Hospital, Charleston, South Carolina. Dr. Stith received his medical degree from the University of Louisville School of Medicine in 1941. He has been assigned to previous military duty with the Navy, serving 18 months in Hawaii, Okinawa and China during World War II.

John Douglas Ruff, M.D., recently associated with the Lexington Clinic for the practice of internal medicine with emphasis on clinical hematology. Dr Ruff, who is a native of South Carolina, was graduated from the Medical College of the State of South Carolina in 1946 and interned at the University of Chicago Clinics, Chicago, Illinois. He has completed postgraduate study in pathology at Tulane University of Louisiana School of Medicine and the University of Vienna, Italy. Beginning in 1950 he took a three year residency at the Mayo Foundation, Rochester, Minnesota.

Claude Wilkes Trapp, Jr., M.D., recently opened an office in Lexington for the practice of ophthalmology. Dr. Trapp is a 1950 graduate of Cornell University Medical College, New York, and interned at New York Hospital, New York City. In St. Louis, Missouri, he took a three year residency in ophthalmology at Barnes Hospital, and completed eight months of postgraduate study at Washington University Medical School. During World War II, Dr. Trapp spent two years as a lieutenant in the United States Navy aboard an aircraft carrier in the Pacific.

Henry F. Chambers, Jr., M.D., recently located in Campbellsville. Dr. Chambers received his medical degree from the University of Louisville School of Medicine in 1952 and interned at the United States Public Health Service Hospital, New Orleans.



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In Memoriam

FRED WHARTON RANKIN, M.D.

Lexington

1886 - 1954

Dr. Fred Wharton Rankin, 67, died at his home in Lexington, May 22, 1954, after an illness for the past two and one-half years. Dr. Rankin was a world-renowned surgeon, honored for having perfected a one-stage surgical procedure for operations on the large bowel.

A leader in organized medicine he was one of three physicians who have served as president of the American Surgical Association, the American College of Surgeons and the American Medical Association.

His most recent honor was bestowed on him in May when he was installed as an honorary fellow of Edinburgh's Royal College of Surgeons. In January, the amphitheater at General Hospital in Louisville was expanded and named the Rankin Amphitheatre.

A native of North Carolina, Dr. Rankin was graduated from the Medical Department of the University of Maryland in 1909. During his life he was a professor of surgery at the University of Louisville School of Medicine, and chief of the surgical section at Mayo Clinic, Rochester, Minnesota. In 1933 he entered private practice in Lexington and was appointed chief of the surgical staff at St. Joseph Hospital, Lexington.

OLIVER PERRY GOODWIN, M.D.

Pleasureville

1875 - 1954

Dr. Oliver Perry Goodwin, of Pleasureville, died May 15, 1954, at the New Castle Sanatorium. Born November 24, 1875, he was seventy-eight years old.

A graduate of the Louisville Medical College in 1903, he had practiced in the community of Pleasureville for more than fifty years.

JAMES C. SPARKS, M.D.

Ashland

1875 - 1954

Dr. James C. Sparks, 79, died at his home in Ashland, June 3, 1954, after a long illness. He was a former chief of staff of the King's Daughters' Hospital, Ashland, and a past president of the Boyd County Medical Society.

A native of Lawrence county, Dr. Sparks

was a graduate of the University of Louisville Hospital College of Medicine. Since 1924 he has practiced in Ashland. Prior to that he practiced in Van Lear and Paintsville, Kentucky.

Dr. Sparks was the father of Clyde C. Sparks, M.D., of Ashland, president-elect of the Kentucky State Medical Association.

J. D. TIMMONS, M.D.

Hanson

1866 - 1954

Dr. J. D. Timmons, retired physician, died at his home in Hanson, May 23, 1954. He was eighty-eight years old. When he retired several years ago because of ill health, he had practiced medicine at Hanson for sixty years.

Dr. Timmons received his doctor of medicine degree from the Medical Department of the University of Louisville in 1896. He was a member of the Kentucky State Medical Association.

JOSEPH H. HARRISON, M.D.

Owensboro

1872 - 1954

Dr. Joseph H. Harrison, 80, died May 17, 1954, at the Owensboro-Daviess County Hospital. He was graduated from Barnes Medical College, St. Louis, Missouri, in 1898, and became a veteran Owensboro physician.

He was a member emeritus of the Daviess County Medical Society and the Kentucky State Medical Association. He remained in active practice until his retirement several years ago.

SAMUEL W. BRISTOW, M.D.

Albany

1873 - 1954

Dr. Samuel W. Bristow, 80, who had practiced for nearly 49 years in Clinton, Cumberland and Wayne Counties, died May 11, 1954, at his home in Albany.

At the time of his death Dr. Bristow was president of the Clinton County Medical Society and was serving the office of Clinton County Coroner in addition to maintaining an active practice.

On October 10, 1953, many persons from the three-county area observed "Doctor Bristow Day" in honor of the veteran general practitioner's 80th birthday, the 48th anniversary of his practice.

Dr. Bristow was graduated from the Medical Department of the University of Tennessee in 1906 and was a member of the Kentucky State Medical Association.

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County Society Reports

CALLOWAY

The monthly meeting of the Calloway County Medical Society was held in the chapel of the Murray Hospital on April 6, 1954, with C. C. Lowry, M.D., president, presiding.

Administrator Warming reported the Blue Cross ad was not run in the local newspaper in March. Hugh Houston, M.D., mo ed that the Blue Cross ads be discontinued. The motion carried.

Kenneth Ross, M.D., suggested that the county society contribute space for advertisement for the North-South Basketball game. It was suggested that the executive Committee recommend a decision for a motion at the next meeting.

In addition to those already mentioned, the following physicians were present: Charles Clark, Robert Hahs, J. C. Hart, C. H. Jones, O. K. Mason, J. A. Outland, John Quertermous, Charles Tuttle and Birdsall Carle.

J. L. Hopson, M.D., Secretary

CALLOWAY

The monthly meeting of the Calloway County Medical Society was held in the chapel of the Murray Hospital on May 4, with C. C. Lowry, M.D., presiding. The society as a group agreed to take no action on contributing space for advertisements for the North-South Basketball Game.

In addition to Dr. Lowry, the following physicians were present: A. D. Butterworth, J. C. Hart, Hugh Houston, C. H. Jones, O. K. Mason, J. A. Outland, John Quertermous, Kenneth Ross, Charles Tuttle, Birdsall Carle, and Administrator Warming.

J. L. Hopson, M.D., Secretary

DAVIESS

The Daviess County Society met May 25, 1954, and elected the following new officers: Joseph Kurre, M.D., president; Clinton M. Lacy, M.D.., vice-president; Thomas Crume, M.D., secretary and treasurer; Howell Davis,

M.D., delegate, Horace Harrison, M.D., and Thomas Milton, M.D., alternate delegates, all of whom live in Owensboro.

The new executive committee will be composed of: J. Edmund Bickel, M.D., chairman, Mack Rayburn, M.D., and William Woolfolk, M.D., all of whom live in Owensboro.

Frank Yarbrough, M.D., is the new chairman of the nominating committee. Other members are J. Edmund Bickel, M.D., Howell Davis, M.D., F. Hayes Threlkel M.D., and Byron Harrison, M.D., all of whom live in Owensboro.

Clinton M. Lacy, M.D., Secretary-Treasurer

McCRACKEN

The monthly dinner meeting of the McCracken County Medical Society was called to order May 26, 1954, with W. K. Sloan, M.D., presiding. A letter was read from the Kentucky State Medical Association relative to the Distinguished Service Award and the Outstanding General Practitioner Award to be presented at the Annual Meeting in Louisville, September 21, 22, and 23.

W. B. Haley M.D., notified the society that all cancer cases were reportable diseases. Dr. Haley moved that the secretary of the cancer society be empowered to forward all cases from all hospitals. The motion carried.

A committee was appointed to work with the cerebral palsy clinic to further progress on its behalf. J. E. Dunn, M.D., T. J. Marshall, M.D., Winfield Stryker, M.D., and Samuel French, M.D., were appointed to serve.

Dr. Sloan referred to the society the wishes of the administration of the Western Baptist Hospital to move the county society library to their hospital. The question was referred to the library committee for a report at the next meeting.

The scientific program was presented by Dr. French, local orthopedist, who discussed "Low Back Pain." Questions and discussion followed.

M. W. Fowler, Jr., M.D., Secretary

PIKE

The Pike County Medical Association had its second annual Eastern Kentucky invitational medical meeting at the Green Meadow Country Club, Thursday, May 20, 1954. All physicians from the surrounding six counties were invited to attend.

Guest speaker was Ormond C. Julian, M.D., associate professor of surgery at the University

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LOUISVILLE, KENTUCKY

of Illinois Medical School, and chief of vascular surgery at Hines Veteran Administration Hospital. His paper dealt primarily with arterial insufficiency and poor venous drainage of the lower extremity.

Dr. Julian stated that blood insufficiency in the lower extremity due to arteriosclerosis has frequently been misdiagnosed and treated as arthritis because of the pain encountered in these patients during exercise, and subsiding with rest. He also emphasized that the progression of symptoms was by stages rather than by daily extension of the symptoms.

He called attention to the fact hat sympathectomy frequently improves the intermittent claudication of pain, however, that it did not improve the course of disease except for improving the blood supply to the skin. The indications for sympathectomy were primarily for the increase of the blood supply to the skin so that it would be enabled to stand trauma better or to facilitate the healing of a lesion of the lower extremity. Amputation, he felt, was the final defeat in treatment of arteriosclerosis.

Russell H. Davis, M.D., Secretary-Treasurer

SCOTT

The Scott County Medical Society met for their regular monthly meeting on June 3, 1954, at the John Graves Ford Memorial Hospital, Georgetown. It was moved that members keep a record of immunizations and that the Health Department nurse secure a copy of these records from the various offices, beginning July 1, 1954. The motion carried.

It was moved that C. R. Lewis, M.D., report to Miss McClanahan that the society will perform tonsillectomies on children who are members of families receiving full state assistance and are willing to reduce their fees $25. The motion carried.

It was moved that every other month the medical society and hospital staff have a joint meeting to begin the first Thursday in July. The motion carried.

In addition to Dr. Lewis, the following members were present: F. W. Wilt, M.D., E. C. Barlow, M.D., H. G. Wells, and H. V. Johnson.

H. V. Johnson, M.D., Secretary

SHELBY-OLDHAM

B. F. Shields M.D., president, entertained members of the Shelby-Oldham Medical Society at the Old Stone Inn, May 27, 1954, and presided at the after dinner meeting.

The secretary read the announcement of the General Practitioner Award from the KSMA. A committee was appointed to determine eligibility of possible candidates.

James Bruce, M.D. Louisville, discussed "Diarrhea in Children" on the scientific program. His talk was well received and discussed by many present.

In addition to those previously mentioned, the following members were present: H. T. Alexander, M.D., M. D. Klein, M.D., George Ray, M.D., W. P. McKee, M.D., H. H. Richeson, M.D., B. B. Sleadd, M.D., H. B. Mack, M.D., A. C. Weakley, M.D., A. L. Heise, D.D.S., George Perrine, M.D., Don Chatham, M.D., and C. C. Risk, D.D.S.

C. C. Risk, D.D.S., Secretary

UNION

Arthur H. Griep, M.D., of the Welborn Clinic, Evansville, Indiana, addressed the May 19 dinner meeting of the Union County Medical and Dental Society at Our Lady of Mercy Hospital, Morganfield. His subject was "Medical Clearance for the Cardiac Patient for Surgical Procedure." He stressed the following aspects: hypertension, congestive failure, angina pectoris, murmurs, myocardial infarction, renal dysfunction, electrolyte troubles, and digitalization.

At a meeting on April 20, 1954, the society voted to support the state immunization drive. The secretary was instructed to advise the local newspaper to give the necessary publicity. An informal discussion on the subject of Renal Conditions was held by the members before adjournment.

Charles P. Bartley, M.D., Secretary-Treasurer

THE NEED FOR A SIMPLE TEST FOR EARLY CANCER

(Continued from page 530)

working with, but for a more specific band of change; that is, notably a deficiency of certain of the amino acids or other chemicals or elements or enzymes, then it may be possible to give the world a satisfactory screening test for the early detection of carcinoma.

Such a test, if it proved to be of a high order of specificity and sensitivity, would be valuable on an individual basis, whether the result proved to be positive or negative. The positive test would point out those persons who needed intensive study for the detection of the site of their malignant tumor growth. Meanwhile, the periodically repeated and consistently negative test would ease the harrassed minds of many persons in a world becoming rapidly more cancer conscious. The solace of a report that "we are quite sure you do not have cancer" would be as valuable to many persons as is an absolute cure of carcinoma to other persons.

Malcolm L. Barnes, M. D.
Louisville

BOOK REVIEWS

ANDERSON'S PATHOLOGY, 2nd edition, 1953, C. V. Mosby Company.

Pathology, one of the younger specialties in medicine, is unique in that though it is a branch of medicine requiring ever-increasing specialization, the practitioners of this division of medicine, in large measure remain "general practitioners" of medicine. That is to say, their problems overlap the problems of the internist, general surgeon, and the specialists in the various fields. The background of the

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pathologist should be one which gives him a speaking acquaintance with the problems of every practitioner of medicine. He must be part anatomist, histologist, embryologist, chemist, bacteriologist, serologist, mycologist, cardiologist, internist, gastroenterologist, teacher and administrator.

Many of the early text books of pathology were undertaken by individuals working separately. Because of this very broad scope of the field, it was difficult for them to give adequate attention to all of the disease processes of the various systems of the body, and many things were passed over rapidly with little more than a mention. A growing tendency in pathology, as in many other fields, is to have one individual serve as editor, or organizer, and many individuals contribute to the general scope of the work. In Anderson we have such a text, and the thirty-two contributors represent a hand-picked group of the country's pre-eminent pathologists. A pathologist's horizons are determined or limited by the staff of the hospital in which he works. That is, he may find that his material is of a very general nature. Or, if the hospital tends to specialization—in for example neurosurgery or orthopedic surgery—he will see much more of this material than those of his colleagues who are in institutions not dong this type of work. Hence the pathologist's location may, of necessity, make him a specialist in a certain narrower field of pathology. Still other pathologists attain eminence in a special division of the science by virtue of making a study of certain diseases or certain systems of the body a hobby.

Dr. Anderson has made excellent use of active and dynamic men in the field in the preparation of his text. Further, as editor-in-chief, he has obviously exercised the clipping shears quite freely, as there is none of the duplication of subject matter which often creeps into works that are undertaken by a number of individuals. The result is a superlative, almost encyclopedic work on general pathology. A very wide variety of diseases and lesions are covered in enough detail to give the reader a basic concise concept of these conditions from the text alone, or the excellent bibliography will set the searcher on the right track if he seeks more detailed information. Beyond being valuable to the student of pathology, it is a book that has a place in the library of every practitioner of medicine as a valued reference work, and we recommend it heartily.

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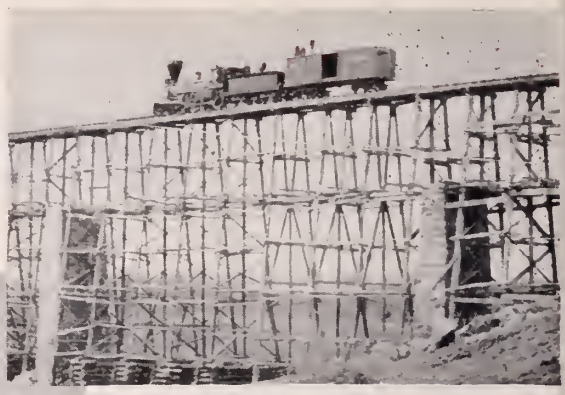
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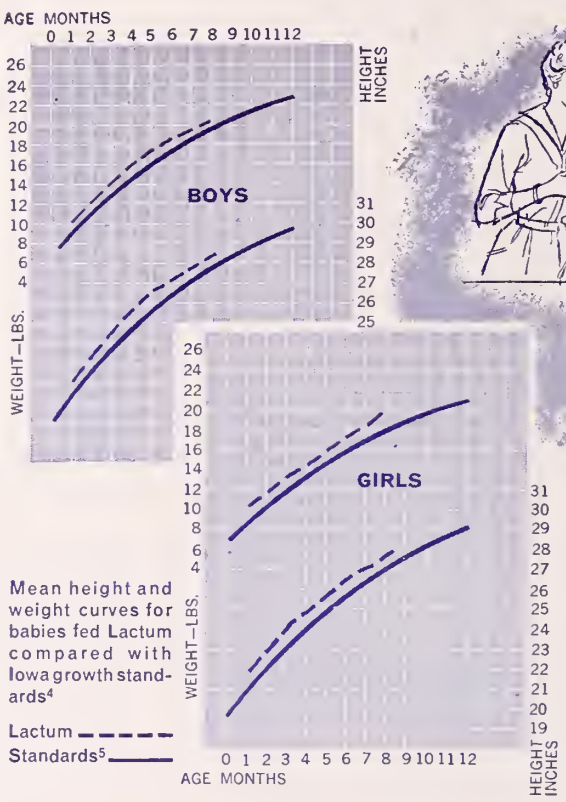
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(1) Jeans, P. C.: In A.M.A. Handbook of Nutrition, Ed. 2, Philadelphia, Blakiston, 1951, p. 275. (2) Albanese, A. A.: Pediat. 8: 455, 1951. (3) Holt, L. E., Jr., and McIntosh, R.: In Holt Pediatrics, Ed. 12, New York, Appleton-Century-Crofts, Inc., 1953, pp. 175-178. (4) Frost, I. H., and Jackson, R. L.: J. Pediat. 39: 585, 1951. (5) Jackson, R. L., and Kelly, H. G.: J. Pediat. 27: 215, 1945.

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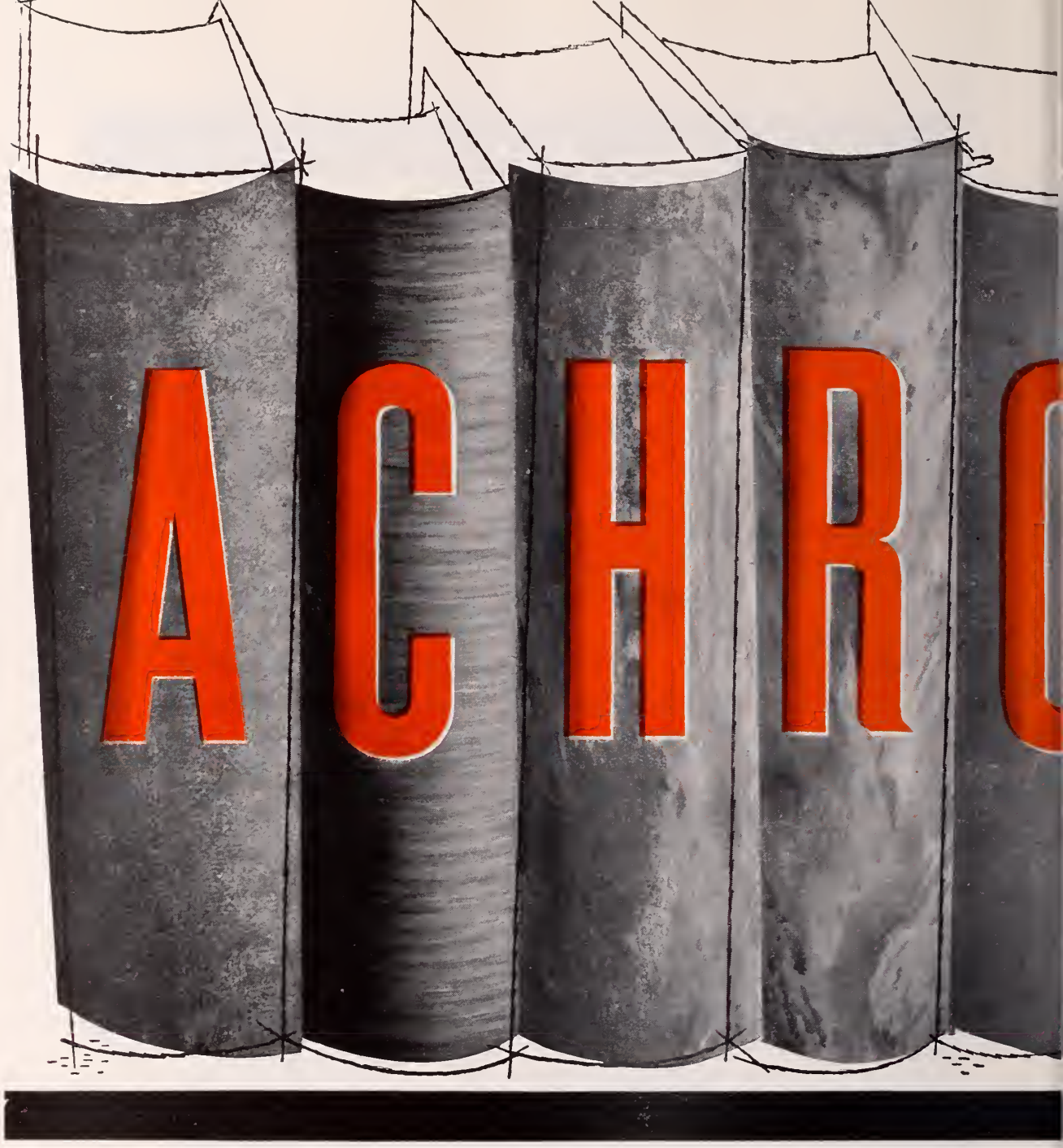
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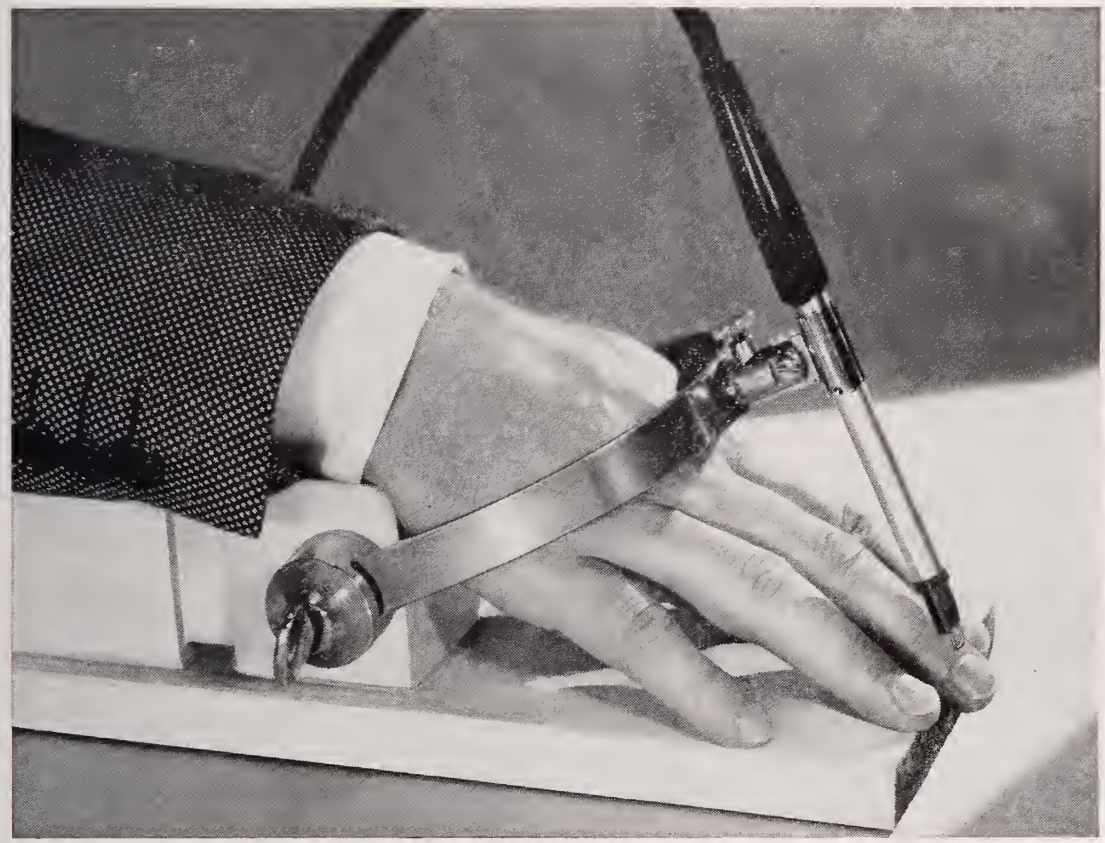
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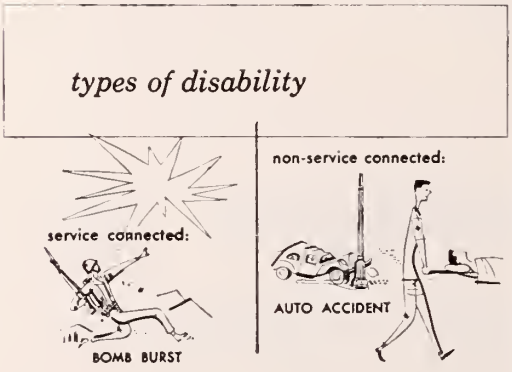
We feel that we owe you not only our best "hospitality", but also our deepest respect and our warmest friendship. And, in some cases, our lives. . . .

For all these reasons, now and always—WELCOME TO THE BROWN HOTEL.

Harold E. Harter
Managing Director

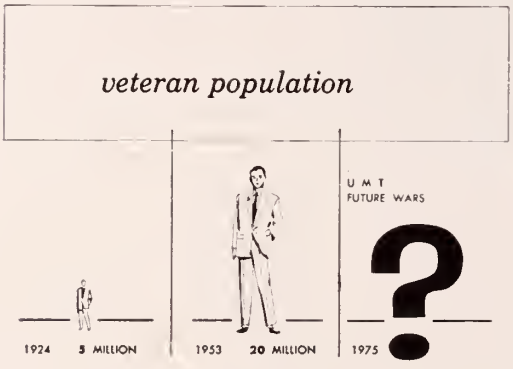
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In Viewing the VA Medical Program . . .



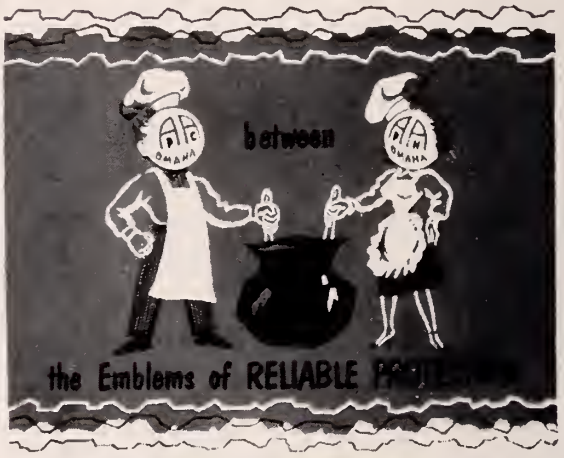
The medical profession fully endorses and supports the medical program of the Veterans Administration through which veterans receive medical care and hospitalization without cost for illnesses or injuries incurred as a result of military service (left). It is felt, however, that the federal government should not assume the responsibility for the medical care of veterans whose disabilities are incurred in civilian life and which have no relationship to their military service.

In Viewing the VA Medical Program . . .



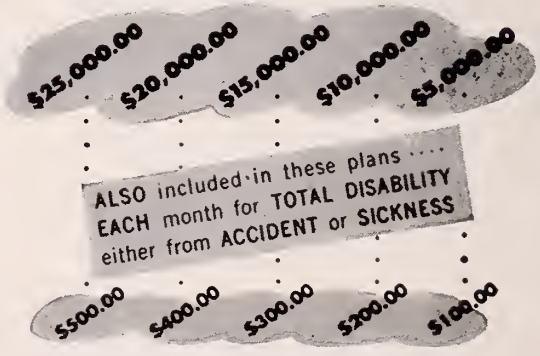
The U. S. veteran population now includes about 40% of all adult males. Under existing legislation, the federal government is obliged to provide "free" medical care for many of these veterans, if they request it. The medical profession questions the soundness of providing medical care at federal expense to veterans with non-service-connected disabilities. It is likely that by 1975 the U. S. will truly be a "nation of veterans." If the VA medical program continues to accept responsibility for the care of veterans with service-connected and non-service-connected disabilities alike it is difficult to see how a complete federal health program can be avoided.

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1. Parsons, L., and Tenney, B., Jr.: M. Clin. North America *34*:1537, 1950.
2. Greenblatt, R. B.: J. Clin. Endocrinol. & Metab. *13*:828, 1953.

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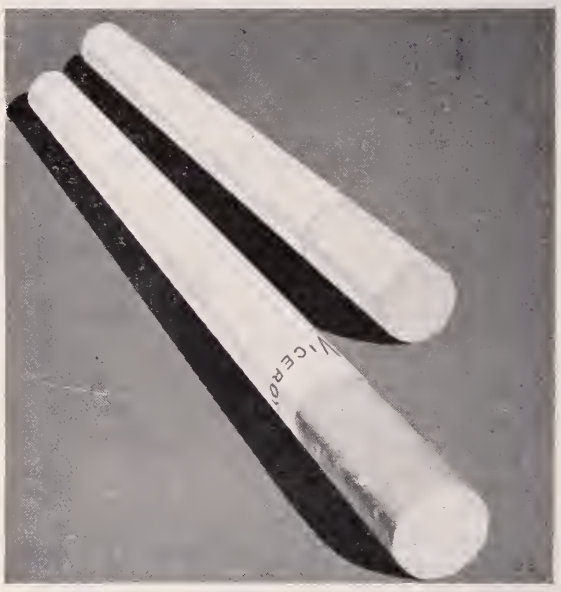


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The smoke is also filtered through Viceroy's extra length of rich, costly tobaccos. Thus Viceroy actually gives smokers *double the filtering action* . . . to double the pleasure and contentment of *tobacco at its best!*

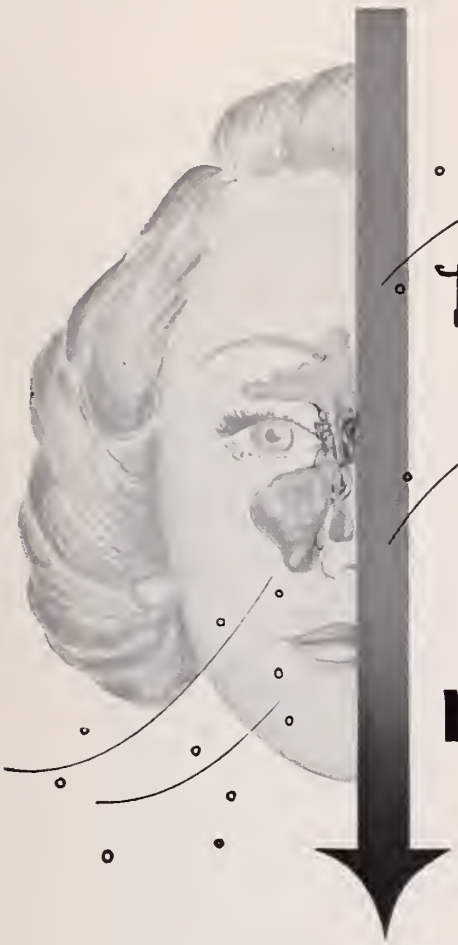


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New King-Size
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To open congested air passages in hay fever

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. . . *reduces nasal engorgement* . . .

promotes aeration . . . encourages drainage

A few drops of Neo-Synephrine 0.25% in each nostril will promptly check mucosal engorgement and hypersecretion, promoting greater breathing comfort over a period of several hours.

The resultant relief to the hay fever sufferer is decidedly gratifying. Prolonged action of Neo-Synephrine makes fewer applications necessary, consequently longer periods of rest and sleep are possible.

Neo-Synephrine does not lose its effectiveness on repeated application and may, therefore, be relied upon to give relief throughout the hay fever season.

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0.5% Solution; 0.25% Spray (unbreakable plastic squeeze bottle)

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1. Van Alyea, O. E., and Donnelly, Allen: *Arch. Otolaryng.*, 49:234, Feb., 1949.

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DOSE: 1 or 2 tablets three to four times a day until the fourteenth day following delivery.

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The JOURNAL of the

Kentucky State Medical Association

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VOL. 52 AUGUST, 1954 NO. 8

OFFICERS OF KENTUCKY STATE MEDICAL ASSOCIATION



J. DUFFY HANCOCK, M. D.

President

CLYDE C. SPARKS, M. D.

President-Elect

Clyde Cecil Sparks was born May 24, 1903, in Lawrence County, Kentucky. The son of a country doctor, James Cecil Sparks, M.D., Dr. Sparks did not immediately follow in his father's footsteps. Following his graduation from Paintsville High School, Dr. Sparks received his B.S. degree from Georgetown College in 1924.

As professor of Science and Mathematics, he taught at the Campbellsville Junior College from 1924 to 1927. In 1926 the young professor married the violin instructor at the college, Mabel Coakley, whose grandfather was one of the founders of the old Russell Creek Academy which later became Campbellsville College. They have one son, Dan Coakley Sparks, who is a graduate student at the Eastman School of Music, Rochester, New York.

After his marriage, Dr. Sparks attended the University of Louisville School of Medicine, graduating in 1932 with the highest scholastic marks in the class. Prior to his graduation he had served as student instructor, from his sophomore year on, in the Anatomy Department.

Elected to AOA membership in 1930, Dr. Sparks was made president of the organization in 1931. This is an early indication of his capacity for leadership. From 1932 to 1934 he was on the Surgical House staff at the Louisville City Hospital, now known as Louisville General Hospital. In 1936 Dr. Sparks established his practice in Ashland, having previously practiced industrial medicine in Fleming, Kentucky.

Three and a half years of service with the United States Navy during World War II interrupted his Ashland practice. During that time Dr. Sparks saw service both in this country and in the Pacific Theatre. He still holds his commission as Commander in the Medical Corps of the Naval Reserve.

Dr. Sparks is a Fellow of the American College of Surgeons and of the Kentucky Surgical Society. He has held active committee appointments within the organizations. At the present time he is a member of the Council of the Kentucky Chapter of the American College of Surgeons.

In addition, he is a member of the Southeastern Surgical Congress and is currently its Councilor for Kentucky. He previously served on its State Executive Committee for Kentucky.

Several scientific papers have been presented by Dr. Sparks at district, state and Southeastern Surgical meetings. A charter member and past president of the Kentucky Society for Obstetrics and Gynecology, Dr. Sparks presented a paper at its organizational meeting.

In Ashland, Dr. Sparks has twice served as president of the staff at King's Daughters' Hospital and has also acted as Chief of Surgical Service on several occasions. Dr. Sparks is active in the Boyd County Medical Society, having held various society offices. He is a member of the Board of Trade, the Rotary Club and the First Baptist Church in Ashland.

This short sketch will serve to highlight the activity and interest in the field of medicine which has characterized Dr. Sparks' life. As the record shows, the president-elect is a keen student of medical organizational work and medical economics. In addition to his excellent medical background, Dr. Sparks' civic-mindedness well qualifies him for the post he is about to assume as the 1954-55 President. The House of Delegates may be commended in their choice.

Vice-Presidents

ROBERTSON O. JOPLIN, M.D.

Louisville



Dr. Joplin was born in Elizabethtown in 1902. He was graduated from the University of Louisville School of Medicine in 1927 and received his surgical training at Gouverneur Hospital and Reconstruction Unit, New York Post, and Graduate Hospital, New York City.

He is an Assistant Clinical Professor of Surgery at the University of Louisville School of Medicine. A leader in organized medicine, he has held the office of vice-president and president of the Jefferson County Medical Society, was a former president of the Louisville Surgical Society and the Kentucky Chapter of the American College of Chest Physicians.



L. C. Sparks

PRESIDENT KENTUCKY STATE MEDICAL ASSOCIATION 1954

Dr. Joplin is on the active staff of Kentucky Baptist Hospital, St. Anthony's Hospital, Masonic Widows and Orphans Home, and Central State Hospital. He is Consultant Surgeon at Hazelwood Tuberculosis Sanitorium.

He holds membership in the American College of Surgeons, the International College of Surgeons, the Southeastern Surgical Congress, the Kentucky Surgical Society and the Southern Medical Association. Dr. Joplin has served as delegate to the KSMA House of Delegates for a number of years.

CHARLES WYATT NORVELL, M.D.

New Castle



Dr. Norvell was born in Campbellsburg, Henry County, in 1915. He received his pre-medical training at the University of Kentucky and was graduated from the University of Louisville School of Medicine in 1941.

Following an internship in Texas, he entered the Army Air Force in 1942 and was graduated as a flight surgeon from the School of Aviation Medicine, Randolph Field, Texas.

During World War II he served as a base surgeon in the China-Burma-India Theatre of Operations. In 1946 Dr. Norvell entered private practice in New Castle. At present he is Medical Consultant to the Henry County Department of Health and Medical Director of the New Castle Sanitarium.

He is an active staff member of the Mallory Taylor Memorial Hospital of La Grange, and a member of the Courtesy Staff of the Norton Memorial Infirmary, Louisville. Dr. Norvell holds membership in his County, State, Southern and American Medical Associations. He is chairman of the KSMA Committee on Rural Health and chairman of the Kentucky Rural Health Council.

KSMA members are urged to purchase tickets for the President's Luncheon, Wednesday, September 22, at their earliest convenience on arriving at Columbia Auditorium. Tickets will be sold both at the Registration Desk and the Education Campaign Booth.

ORION LEON HIGDON, M.D

Paducah



Dr. Higdon was born in 1902 at Fancy Farm in Graves County. Soon after he received his medical degree and completed his internship at St. Joseph's Hospital, he began practicing in Paducah.

After ten years of general practice there, Dr. Higdon attended the University of Pennsylvania School of Medicine in Philadelphia for postgraduate study. Since then he has limited his practice to obstetrics and gynecology.

Always active in organized medicine, Dr. Higdon has served as secretary of the McCracken County Medical Society for twelve years, and almost continuously as a delegate to the Kentucky State Medical Association. In the past he has served as president of his county society and now immediate president of the Kentucky Obstetrical and Gynecologic Society.

He holds membership in the American Academy of Obstetrics and Gynecology and the American College of Surgeons. He is a member of the active staff of Riverside, Illinois, Central and Western Baptist Hospitals. For two years he was Chief of Staff at Riverside Hospital.

Secretary-Editor

BRUCE UNDERWOOD, M.D.

Louisville



Dr. Underwood, a native of Louisville, is secretary and general manager of the KSMA and editor of the Journal of the association. In addition he serves as Commissioner of Health for the Commonwealth of Kentucky.

At the 1953 Annual Meeting of the KSMA, Dr. Underwood was elected to serve a second five-year term of office as secretary-editor. In 1948, upon the death of P. E. Blackerby, M.D., Dr. Underwood was appointed to the position of commissioner and secretary-editor.

He received his medical education at the University of Louisville School of Medicine. After finishing his internship at Wil-

liam Beaumont General Hospital, El Paso, Texas, Dr. Underwood was engaged in public health work as a county health officer in Kentucky and Florida and in general practice for several years. He is a diplomate of the American Board of Preventive Medicine.

Dr. Underwood continues to carry out the responsibilities of his office in the manner desired by the membership and to seek constructive suggestions in conducting the affairs of his office. To each member of the association he wishes to express his appreciation for the support and cooperation rendered during the past six years.

Treasurer

WOODFORD B. TROUTMAN, M.D.

Louisville



Dr. Troutman has served the KSMA as Treasurer for the past eight years, having been first elected to the office by the House of Delegates in 1946. His efficient service rendered to the Association has been a valuable contribution and is deeply appreciated by the membership.

In 1924, Dr. Troutman entered the practice of general medicine in Louisville. In 1929 he studied in Vienna, London, and Edinburgh, specializing in cardiology. After returning to Louisville in 1930, he has practiced his specialty continuously except while serving with the Army Air Force during World War II.

Born in Bullitt County, January 15, 1897, Dr. Troutman was graduated from the University of Louisville School of Medicine in 1921, and interned at McKeesport, Pennsylvania Hospital and Bellevue Hospital, New York City.

He holds membership in the American Heart Association, the American College of Physicians, and the American Medical Association.

Annual Meeting Programs will be supplied at the Registration Desk. If you failed to receive a program when you registered, a staff member at the Registration Desk will give you one upon request.

Speaker

CHARLES A. VANCE, M.D.

Lexington



Dr. Vance was well prepared to assume the duties as second Speaker of the KSMA House of Delegates, an office created in 1951 upon the recommendation of the Committee on Constitution and By-Laws to relieve the President of this added responsibility.

Before the gavel was passed to him, Dr. Vance served a term as Vice-Speaker of the House, diligent and ever in readiness to preside if called upon to do so in the absence of the Speaker.

Active in KSMA activities, Dr. Vance is serving as Chairman of the KSMA Professional Relations Committee and is a member of the Medical School Advisory Committee. During the past year he was Chairman of the Board of Directors of the McDowell Memorial Foundation.

Born in 1880, Dr. Vance received his medical education at the Medical Department of Kentucky University, graduating in 1903. He is certified by the American Board of Surgery. Dr. Vance holds membership in the following professional associations: the Southern Surgical Association, the American College of Surgeons, the American Medical Association, and the American Association for the Surgery of Trauma.

Vice-Speaker

E. W. JACKSON, M.D.

Paducah



Dr. Jackson is a man well qualified for the position of Vice-Speaker of the KSMA House of Delegates. Because of the standby nature of this office, it requires an experienced man capable of assuming its duties with assurance and a command of presiding officer techniques.

His past leadership in organized medicine and valuable service to the association indicate Dr. Jackson's presiding experience. In 1946 he served as President

of the Kentucky State Medical Association. Prior to holding this office, he fulfilled two terms as Vice-President of the KSMA.

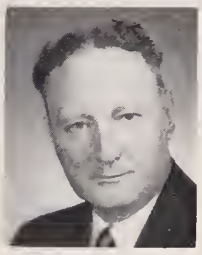
In addition, Dr. Jackson has served as President of the Southwestern Kentucky Medical Society. He was graduated from the Medical Department of the University of Louisville in 1912, serving as class president. He interned at Louisville General Hospital and Eastern Indiana Hospital.

During World War I, Dr. Jackson served in the Medical Corps of the United States Army, attaining the rank of Captain. He is a member of the Southeastern Surgical Congress, the American College of Surgeons, and the American Medical Association.

Delegates to the A.M.A.

W. CLARK BAILEY, M.D.

Harlan



Dr. Bailey has served as a delegate to the American Medical Association since 1944 except when holding the office of KSMA President and President-Elect during the years 1950 and 1951, respectively.

His birthplace was Harlan in 1900 where he has practiced to the present day. Dr. Bailey received his Doctor of Medicine degree from the University of Louisville School of Medicine in 1926. He took graduate training at the Tuberculosis Sanatorium in Louisville, Children's Hospital, and Louisville City Hospitals.

Currently, he is a chairman of the KSMA Committee on the Corporate Practice of Medicine, a consultant on the Medico-Legal Committee, and a member of the Legislative Committee, the Professional Relations Committee and the Advisory Committee to the UMWH Welfare and Retirement Fund.

BRUCE UNDERWOOD, M. D.

Louisville

Dr. Underwood has served the Association as a delegate to the AMA since 1950. He was elected to a second term as delegate from Kentucky at the 1951 Annual Meeting and is currently filling his third term. At the 1953 meeting he was elected to serve as delegate for a two year term. Dr. Underwood has served on several committees of the AMA House of Delegates and has sponsored legislation voted by the House.

Orator in Medicine

ROBERT S. DYER, M.D.

Louisville



Robert S. Dyer, M.D., was born in Owensboro, June 3, 1915. He received his Doctor of Medicine degree from the University of Louisville School of Medicine in 1940, and interned at St. Joseph Infirmary, Louisville.

He received postgraduate training in internal medicine at John Sealy Hospital, University of Texas, Galveston, and was senior assistant and chief resident at Louisville General Hospital for two years. Dr. Dyer served in the Medical Corps of the U. S. Army during World War II, attaining the rank of Captain.

He began practicing internal medicine in Louisville in 1946. At present he is an attending consultant at the Veterans Hospital, and an Associate in the Department of Medicine at the University of Louisville since 1951.

Dr. Dyer is on the active staff of St. Joseph Infirmary, St. Anthony's Hospital, the Kentucky Baptist Hospital and Norton's Infirmary, Louisville. He is certified by the American Board of Internal Medicine and the Associate American College of Physicians.

Orator in Surgery

JOHN E. HAYNES, M.D.

Madisonville



Dr. Haynes was born in Calhoun in 1908. He attended Calhoun High School, Western Kentucky State College and was graduated from the University of Louisville School of Medicine in 1933.

He served a rotating internship at St. Elizabeth's Hospital, Covington, and took a residency in surgery at Norton's Infirm-

ary, Louisville. Dr. Haynes spent three and one half years in the Medical Corps of the Army of the United States during World War II.

From June, 1942 to January, 1946, Dr. Haynes served as Ward Officer and Chief of Surgical Service of the 19th Field Hospital and Chief of the General Surgical Section of the 19th Station Hospital.

He attained the rank of Lieutenant-Colonel in the medical corps. Dr. Haynes finished a residency in general and orthopedic surgery at Kennedy Veterans Administration Hospital, Memphis, Tennessee, in 1953.

Delegates Listed to Attend Sessions, Sept. 20, 22

The first session of the House of Delegates of the Kentucky State Medical Association will convene in the Columbia Auditorium, Monday, September 20, 1954, at 7 p. m., Central Daylight Saving Time, according to Charles A. Vance, M.D., Lexington, speaker. Delegates may register at 6 pm.

Reports, resolutions and new business will be introduced at the opening session, Monday evening, and assigned to the proper reference committee by the speaker. After considering these matters in meetings Tuesday afternoon, the committees will report on each one at the second meeting of the House on Wednesday evening.

The second session of the House of Delegates will be held Wednesday evening, September 22, at 7 p.m. At this meeting action will be taken on the reports and new officers elected. Any member of the Association who is in good standing is invited to attend both of these sessions.

Each society is entitled to at least one delegate or permitted a delegate for each 25 active members or major portion thereof. Delegates certified to the KSMA Headquarters Office at the time of publication by the component county medical societies as their representatives are listed below.

DELEGATES - 1954

Adair: George O. Nell, Columbia
Allen: John Meredith, Scottsville
Anderson: Boyd Caudill, Lawrenceburg
Barren: William C. Wells, Glasgow
Bath: B. R. Wilson, Sharpsburg
Bell: Charles B. Stacy, Pineville
Bourbon: Jesse W. Smith, Paris
Boyd: Paul Holbrook, Ashland; W. V. Lyon, Ashland
Boyle: Chris Jackson, Danville
Breathitt: Price Sewell, Jr., Jackson
Breckinridge: John A. Kincheloe, Hardinsburg (deceased); W. H. Brown, Irvington (alternate)
Bullitt: Patrick J. Murphy, Lebanon Junction
Butler: D. G. Miller, Jr,. Morgantown
Caldwell: Ralph L. Cash, Princeton
Calloway: John Quertermous, Murray
Campbell-Kenton: W. V. Pierce, Covington; Richard J. Rust, Newport; William Temple, Covington; A. J. Vesper, Covington; Paul Robinson, Covington
Carlisle: Thomas T. Brackin, Bardwell
Carroll: H. V. Stewart, Carrollton
Carter: J. Watts Stovall, Grayson
Casey: G. J. Sweeney, Liberty
Christian: H. B. Stone, Hopkinsville
Clay: W. E. Becknell, Manchester
Clinton: E. A. Barnes, Albany
Crittenden: J. O. Nall, Marion
Cumberland: Joseph Schickel, Burkesville
Edmonson: M. B. Wilkes, Jr., Brownsville
Elliott: John F. Greene, Sandy Hook
Estill: R. R. Snowden, Ravenna
Fayette: C. C. Johnston, Lexington; L. E. Hurt, Lexington; R. G. Elliott, Lexington; John Scott, Lexington; Theodore Adams, Lexington; Louis Bosworth, Lexington; Carl Fortune, Lexington
Fleming: W. A. Graham, Flemingsburg
Floyd: Melvin V. Wicker, Wayland
Franklin: William S. Snyder, Jr., Frankfort
Fulton: D. L. Jones, Fulton
Garrard: V. G. Kinnaird, Lancaster
Grant: Lenore Chipman, Williamstown
Graves: Richard Colley, Mayfield
Grayson: C. L. Bland, Leitchfield
Green: Robert L. Shuffett, Greensburg
Greenup: J. G. Boggs, Russell
Hardin: C. F. Long, Elizabethtown
Harlan: Phillip J. Begley, Harlan; E. M. Howard, Jr., Harlan
Harrison: J. P. Wyles, Cynthiana
Hart: Samuel A. Rector, Munfordville
Henderson: G. W. White, Henderson
Henry: G. E. McMunn, Eminence
Hickman: V. A. Jackson, Clinton
Hopkins: R. J. Dancey, Madisonville
Jefferson: Everett H. Baker, Louisville; Byron Bizot, Louisville; Glenn W. Bryant, Louisville; Herbert L. Clay, Louisville; Carlos A. Fish, Louisville; Hunt B. Jones, Louisville; Charles H. Maguire, Louisville; Roy A. Moore, Louisville; Carlisle Morse, Louisville; John M. Townsend, Louisville; John D. Trawick, Jr., Louisville; C. Victor Atherton, Louisville; William H. Bizot, Louisville; William A. Blodgett, Louisville; Morgan R. Col-

bert, Louisville; Daniel Costigan, Louisville; James B. Douglas, Louisville; Gordon L. Green, Louisville; Robertson O. Joplin, Louisville; Eugene H. Kremer, Jr., Louisville; Paul Mapother, Louisville; George B. Sanders, Louisville; Stanley T. Simmons, Louisville; Karl D. Winter, Louisville

Jessamine: C. A. Neal, Nicholasville
Johnson: Charles L. Preston, Paintsville
Knott: M. F. Kelly, Hindman
Knox: C. R. Messer, Barbourville
Larue: J. D. Handley, Hodgenville
Laurel: R. E. Pennington, London
Lee: A. B. Hoskins, Beattyville
Letcher: Carl Pigman, Whitesburg
Lewis: C. C. Merritt, Tollesboro
Lincoln: H. I. Frisbie, Stanford
Livingston: Frank C. Coffield, Salem
Logan: J. P. Glenn, Russellville
Lyon: J. E. Cotthoff, Kuttawa
Madison: J. Bates Henderson, Berea
Marion: S. C. Clarkson, Lebanon
Marshall: William J. Colburn, Calvert City
Mason: William H. Cartmell, Maysville
McCracken: James A. Ward, Paducah; Leon Higdon, Paducah
McCreary: G. C. Meece, Whitley City
McLean: Gerald Edds, Calhoun
Meade: Alfred Glattauer, Brandenburg
Menifee: D. L. Graves, Frenchburg
Mercer: T. O. Meredith, Harrodsburg
Metcalfe: E. S. Dunham, Edmonton
Monroe: William R. Bushong, Tompkinsville
Montgomery: J. M. Bush, Mt. Sterling
Morgan: R. L. Gullett, West Liberty
Muhlenberg: H. H. Woodson, Jr., Greenville
Nelson: Tyre G. Forsee, Bardstown
Ohio: Paul E. Goode, Hartford
Oldham: J. T. Walsh, LaGrange
Owen: Paul Harrison, Owenton
Owsley: Mildred E. Gabbard, Booneville
Pendleton: Fred C. Hauck, Falmouth
Perry: C. D. Snyder, Hazard
Pike: Adam G. Osborne, Pikeville
Pulaski: A. Weddle, Somerset
Rockcastle: George H. Griffith, Mt. Vernon
Russell: M. M. Lawrence, Jamestown
Scott: H. G. Wells, Georgetown
Shelby: A. D. Doak, Shelbyville
Simpson: L. F. Beasley, Franklin
Taylor: W. B. Atkinson, Campbellsville
Todd: Ralph D. Lynn, Elkton
Trigg: Elias Futrell, Cadiz
Trimble: Carl Cooper, Jr., Bedford
Union: G. B. Carr, Sturgis
Warren: J. T. Gilbert, Jr., Bowling Green
Washington: M. A. Coyle, Springfield
Wayne: F. L. Duncan, Monticello
Whitley: Keith P. Smith, Corbin
Woodford: George H. Gregory, Versailles

House to Hear Report of Council; New Councilors Listed

The Council will have held four meetings by the time the 1954 session of the House of Delegates is called to order, and its Executive Committee will have convened five times. The Council, which is the interim governing body of the association, meets between the sessions of the House of Delegates.

Members of the House of Delegates at the 1954 session as well as all KSMA members will be interested in reading the report of its 1954 activities which will be submitted to the House, September 20, by its Chairman, J. Farra Van Meter, M.D., Lexington.

A perusal of this report will once again demonstrate the strength and vigor of the leadership the Council is providing the association. It will also highlight the amount of time, travel and effort the members of the Council contribute to organized medicine in Kentucky as they serve you.

Five new councilors were elected by the 1953 session of the House of Delegates under the new method of staggering the terms. As provided by the By-Laws, five new councilors are automatically elected each year.

Retiring councilors were Joseph I. Greenwell, M.D., New Haven, Fourth District; J. R. Cummings, M.D., Flemingsburg, Ninth District; Carl Norfleet, M.D., Somerset, Twelfth District; Clyde C. Sparks, M.D., Ashland, Thirteenth District, and Paul B. Hall, M.D., Paintsville, Fourteenth District.

The new councilors are:

W. KEITH CRUME, M.D.
Bardstown
Fourth District

Dr. Crume was born in Bardstown, Kentucky, on December 21, 1905. He received a degree in pharmacy in 1926 from the Louisville College of Pharmacy and later obtained his medical degree from the University of Louisville School of Medicine in 1934.

For three years he interned at Louisville General Hospital. In 1937 he located in Bardstown where he has continued practicing to the present time. Dr. Crume is a member of the Phi Chi and Alpha Omega Alpha medical fraternities.

For several years he served as president

of the Nelson County Medical Society. He is a member of the KSMA Physicians Placement Committee and the American Medical Association.

Dr. Crume was the first chief of staff of Flaget Memorial Hospital, Bardstown. For the past two years, he has been a member of the City Council of Bardstown.

JAMES McKINLEY STEVENSON, M.D.

Brooksville

Ninth District

Dr. Stevenson was born April 27, 1895, at Bratton, Kentucky. He received his premedical training at the University of Kentucky and his medical degree from the University of Louisville School of Medicine in 1917.

During the first World War Dr. Stevenson served as a Captain in the Medical Corps of the United States Army. Since then he has been engaged in the private practice of medicine and surgery.

Active in organized medicine, Dr. Stevenson has served as president of the Bracken County Medical Society, secretary-treasurer of the Licking Valley Medical Society, and is a member of the KSMA and AMA.

He is a courtesy staff member of Hayswood Hospital of which he was president in 1948, and is a member of the KSMA Committee on Rural Health. Dr. Stevenson has served as a member of the Board of Education in Brooksville and later of the Bracken County Board for ten years. He is a past commander of his American Legion Post.

GARNETT J. SWEENEY, M.D.

Liberty

Twelfth District

Dr. Sweeney was born in Liberty, June 19, 1914. He received his B.S. degree in 1935 from the University of Kentucky. In 1939 he was graduated from the University of Louisville School of Medicine and interned at Charity Hospital, New Orleans.

Dr. Sweeney was installed as the new president of the Kentucky Chapter of the American Academy of General Practice in April, 1954. Since 1940 he has practiced in Liberty.

He is on the staff of the Casey County War Memorial Hospital, Liberty. Dr. Sweeney is an avid exponent of developing and maintaining adequate postgraduate refresher courses.

He is a member of the KSMA Committee on Medical Education. Dr. Sweeney is active in local civic affairs.

CHARLES BOWMAN JOHNSON, M.D.

Russell

Thirteenth District

Dr. Johnson, a native of Pike County, was born in 1899. He received his premedical education at Centre College, Danville, and his Doctor of Medicine degree from the University of Louisville School of Medicine in 1928.

He practiced in the coal fields of Eastern Kentucky for one year before locating at Russell, where he has continued in private practice since 1929. Dr. Johnson is a member of the staff and a past president of the King's Daughters' Hospital, Ashland.

In 1953, he was a vice-president of the Kentucky State Medical Association. He is a senior fellow of the Southeastern Surgical Congress and is the medical consultant to the Greenup County Health Department.

In addition, he holds membership in the American Geriatrics Society and is active in local civic affairs.

JOHN G. ARCHER, M.D.

Prestonsburg

Fourteenth District

Dr. Archer was born in Prestonsburg, October 10, 1908. His formal education began at the grade school in his home town and continued into high school at Greenbrier Military School, Lewisburg, West Virginia.

He attended the University of Kentucky for two years and obtained his Doctor of Medicine Degree from the University of Louisville School of Medicine in 1933. Dr. Archer has practiced exclusively in Prestonsburg since his graduation.

At present he is co-owner of the Prestonsburg General Hospital, Inc., which has been in existence since 1944. He is a member of the Floyd County Medical Society.

Dr. Archer also holds membership in the Southern Medical Association, the American Medical Association, and has been a councilor for the 14th district of the Kentucky State Medical Association since 1953.

COUNCILORS

First District



J. VERNON PACE
Paducah

Second District



WALTER L. O'NAN
Henderson

Third District



DELMAS M. CLARDY
Hopkinsville

Fourth District



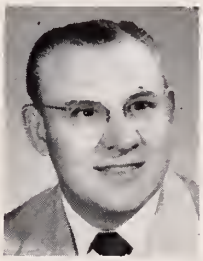
W. KEITH CRUME
Bardstown

Fifth District



R. R. SLUCHER
Buechel

Sixth District



*L. O. TOOMEY
Bowling Green

Seventh District



*B. B. BAUGHMAN
Frankfort

Eighth District



EDW. B. MERSCH
Covington

Ninth District



J. M. STEVENSON
Brooksville

Tenth District



*J. F. VAN METER•
Lexington

Eleventh District



*HUGH MAHAFFEY
Richmond

Twelfth District



GARNETT J. SWEENEY
Liberty

Thirteenth District



CHARLES B. JOHNSON
Russell

Fourteenth District



JOHN ARCHER
Prestonsburg

Fifteenth District



EDWARD WILSON
Pineville

* Member, Executive Committee

• Chairman

Dr. Vance Appoints Reference Committees For '54 Session

Delegates who will serve on the various Reference Committees during the 1954 session of the House of Delegates, have been appointed by Speaker of the House, Charles A. Vance, M.D., Lexington.

The Reference Committees will meet in the customary rooms at the Columbia Auditorium, in Louisville, Tuesday afternoon, September 21, at 2 p.m., Central Daylight Time, Dr. Vance said. At this time, the committees will consider some fifty-odd reports of officers, the Council and Committees made to the House of Delegates and referred to the various Reference Committees by Speaker Vance at the first meeting of the House, which will be held Monday night at 7 p. m. Central Daylight Time at the Auditorium.

Any member of the association, who would like to be heard on any of the issues presented to the House in any of the reports, is urged to attend the meeting of the Reference Committee at 2 p.m. on the 21st, and make his views known, Dr. Vance said. If the member does not know the number of the Reference Committee to which the report is assigned, this information can be obtained Tuesday morning at the temporary quarters of the Headquarters Office in the Auditorium.

"Every effort will be made to see that any delegate or member that wishes to testify may do so before any of these committees Tuesday afternoon, on any point raised in any of the reports of the Council, officers, or committees," Dr. Vance stated. "We are most anxious that every member who wants to appear on any issue under consideration may have the opportunity to do so."

After the Reference Committees have held all discussion on reports assigned to them, the committees will go into executive session, study the reports and testimony, then prepare recommendations on the report to the House. Reference Committee reports will be submitted to and acted on by the House at its second meeting, Wednesday evening, September 22 at 7 p.m. Registration of the delegates for both meetings of the House begin at 6 p.m. Central Daylight Time.

Dr. Vance has announced the following appointments for the 1954 Reference Committees:

Reference Committee No. 1—Reports of Officers and Councilors

E. M. Howard, M.D., Harlan, Chairman
Lawrence T. Minish, Jr., M.D., Louisville, Vice-Chairman
C. F. Long, M.D., Elizabethtown
Wendell V. Lyon, M.D., Ashland
J. Albert Vesper, Jr., Covington

Reference Committee No. 2—Reports on Medical Care, Medical Education, Hospitals and related subjects

W. Vinson Pierce, M.D., Covington, Chairman
Richard G. Elliott, M.D., Lexington, Vice-Chairman
Garnett J. Sweeney, M.D., Liberty
Chris Jackson, M.D., Danville
George Archer, M.D., Prestonsburg

Reference Committee No. 3—Reports on Legislation and Public Relations

Richard J. Rust, M.D., Newport, Chairman
Gradie R. Rowntree, M.D., Louisville, Vice-Chairman
Carl Fortune, M.D., Lexington
Ralph D. Lynn, M.D., Elkton
Donald L. Graves, M.D., Frenchburg

Reference Committee No. 4—Reports on Miscellaneous Business

T. O. Meredith, M.D., Harrodsburg, Chairman
Wyatt Norvell, M.D., New Castle, Vice-Chairman
Karl D. Winter, M.D., Louisville
Everett H. Baker, M.D., Louisville
Price Sewell, Jr., M.D., Jackson

Reference Committee No. 5—Reports on Miscellaneous Business

Charles B. Stacy, M.D., Pineville, Chairman
John C. Quertermous, M.D., Murray, Vice-Chairman
Roy H. Moore, Jr., M.D., Louisville
Kenneth L. Barnes, M.D., Princeton
Frank Duncan, M.D., Monticello

Credentials Committee No. 6

Glenn W. Bryant, M.D., Louisville, Chairman
H. C. Denham, M.D., Maysville
Ralph L. Cash, M.D., Princeton

Alternate Committee Members

H. G. Wells, M.D., Georgetown
John D. Handley, M.D., Hodgenville
William E. Becknell, M.D., Manchester
L. E. Hurt, M.D., Lexington

Guest Speakers

E. PERRY McCULLAGH, M.D.*

Cleveland



E. Perry McCullagh, M.D., has been head of the Section of Endocrinology and Metabolism at the Cleveland Clinic since 1934, and a member of the staff of the clinic since 1929.

A native Canadian, he is a 1924 graduate of the University of Manitoba Faculty of Medicine. Dr. McCullagh interned in Vancouver, British Columbia, and also practiced there early in his medical career.

At the Cleveland Clinic he took a surgical and neurosurgical fellowship before joining the staff. Dr. McCullagh holds membership in the American College of Physicians, the American Board of Internal Medicine, the Endocrine Society, and the American Urological Association, among others.

As guest speaker for the Kentucky Chapter of the American College of Physicians, Dr. McCullagh will discuss "Differential Diagnosis of Pituitary Tumors." His topic for the General Scientific Session will be "Treatment of Hyperthyroidism."

JOHN C. PETERSON, M.D.*

Milwaukee



John C. Peterson, M.D., in 1953 assumed the responsibility of organizing the Department of Pediatrics at Marquette University School of Medicine, Milwaukee, Wisconsin, where his present position is Professor and Director of Pediatrics.

From 1938 to 1953 Dr. Peterson was attached to the teaching staff of Vanderbilt University School of Medicine, Nashville, Tennessee, in the Department of Pediatrics. During that time he attained the position of Associate Professor.

His chief interests in medical research have been in the field of infectious diseases and immunology. Dr. Peterson was graduated in 1931 from Vanderbilt University School of Medicine and obtained postgraduate medical training at University Hospitals of Western Reserve, Boston City Hospital, Vanderbilt University Hospital and Cornell Medical College.

Before the General Scientific Session, Dr. Peterson will discuss "Immunizations in Infancy and Childhood." As guest speaker for the Kentucky Chapter of the American Academy of Pediatrics, his subject will be "BCG Vaccination."

JOHN PARKS, M.D.*

Washington, D. C.



John Parks, M. D., has been Professor of Obstetrics and Gynecology at the George Washington University School of Medicine, Washington, D. C. since 1944. He holds three degrees from the University of Wisconsin, attaining his A.B. degree in 1930, a B.S. in 1932, and his medical degree in 1934.

Dr. Parks interned at Cincinnati General Hospital and took a residency in Obstetrics and Gynecology at Wisconsin General Hospital, Madison, from 1935 to 1937, where he was an instructor in pathology until 1938.

For six years, from 1938-1944, Dr. Parks was Chief Medical Officer in Obstetrics and Gynecology at Gallinger Municipal Hospital, Washington, D. C. He is a member of the Board of Directors of the American Board of Obstetrics and Gynecology.

"Obstetric Misconceptions" is the topic Dr. Parks will discuss before the General Scientific Session. As guest speaker of the Kentucky Obstetrical and Gynecologic Society, he will present a paper entitled "Operative Obstetrics" to the group.

*Indicates that the speaker in addition to addressing one of the General Scientific Sessions of the KSMA Annual Meeting is also scheduled to speak before a specified specialty group.

CURTISS B HICKCOX, M.D.*

Hartford, Conn.



Curtiss B. Hickcox, M.D., was born in Watertown, Connecticut, in 1913. He attended Middlebury College in Vermont, where he received his B.S. degree in 1934. He was graduated from Tufts College Medical School, Boston, Massachusetts, in 1938.

Dr. Hickcox interned at Waterbury Hospital and took residency training in anesthesiology at Hartford Hospital, Hartford, Connecticut, from 1939 to 1941. From 1946 to 1949 Dr. Hickcox was Professor and Head of the Department of Anesthesiology at Temple University Medical School and Hospital, Philadelphia.

At present he is an Associate of the Department of Anesthesiology of Hartford Hospital, having served as Acting Chief from 1942 to 1945 and later as Assistant. He is Contract Surgeon (Anesthesiology) at the Veterans' Administration Hospital, Newington, Connecticut, and senior anesthesiologist at several other Connecticut hospitals.

He is a certified member of the American Board of Anesthesiology. Dr. Hickcox will discuss "Recommended Expansion of Interests in Anesthesiology" before the General Scientific Session and "Further Experiences with Hypotension During Surgical Procedures" before the Kentucky Society of Anesthesiologists.

RALPH M. LARSEN, M.D.*

Nashville

Ralph M. Larsen, M.D., was born in Underhill, Wisconsin, in 1903. He received his medical education at Vanderbilt University School of Medicine, graduating in 1930.

From 1941-1952, Dr. Larsen was Chief of Surgical Out-Patient Service and Chief of Children's Surgical Service at Vanderbilt. Since his graduation he has been associated with the medical school of his alma mater.

After taking two residencies in surgery, he became an Instructor in Surgery in 1934 and attained the title of Assistant Professor in 1938. During 1940 he was made Associate Professor of Surgery.

Dr. Larsen is a member of the Southeastern Surgical Association, the American College of Surgeons, and the Society of University Surgeons. "Hashimoto's Disease" is the title of the paper he will discuss before the General Scientific Session. As a special guest speaker of the Kentucky Chapter of the AAGP, Dr. Larsen will speak on "Hernia in Children."

RAYMOND E. MYERS, D.D.S.

Louisville



Raymond E. Myers, D.D.S., is the Dean of the University of Louisville School of Dentistry. In his present position he is also Professor and Head of the Department of Restorative Dentistry.

He received his D.D.S. degree from the University of Louisville School of Dentistry in 1926, and his B. S. degree in 1932. An honorary F.A.C.D. was awarded him in 1938.

Dr. Myers is chairman of the Socio-Economics Committee of the American College of Dentists, a past president of the Louisville District Dental Society, is a member of the executive committee of the Kentucky State Dental Association, and chairman of the Foreign Relations Committee of the American Association of Dental Schools.

During the summer of 1949 he spent a month in England and Scotland studying the National Health Service of Britain under the sponsorship of the American College of Dentists. The title of his presentation before the General Scientific Session is "Socialized Dentistry and Its Relation to Children."

In place of the general scientific session Wednesday afternoon, there will be eight specialty groups meeting simultaneously in the Columbia Auditorium. These scientific presentations will start at 2:00 and 2:30 p.m. and continue through 4:30 p.m., with thirty minute intermissions to visit exhibits at 3:00 p.m.

PHILIP THOREK, M.D.*

Chicago



Philip Thorek, M.D., Clinical Associate Professor of Surgery at the University of Illinois College of Medicine, received his medical education at this institution, graduating in 1931. He was born in 1906.

Dr. Thorek, in his local community, is Attending Surgeon at Cook County Hospital and Professor of Surgery for the Cook County Postgraduate School of Medicine. He is author of texts entitled, "Anatomy in Surgery" and "Diseases of the Esophagus."

In addition, Dr. Thorek holds membership in a number of medical associations: the American Board of Surgery, the American College of Surgeons, the International College of Surgeons, the American Board of Anatomists, and the American College of Chest Physicians.

"Diagnosis and Treatment of Diseases of the Breast" is the subject of Dr. Thorek's presentation before the General Scientific Session. In addition, he will address the Southeastern Congress as guest speaker. Before this group, he will discuss "Pitfalls in Gall Bladder and Common Duct Surgery."

JAMES H. WALL, M.D.*

White Plains, N. Y.



James H. Wall, M.D., is currently serving as Associate Professor of Clinical Psychiatry at Cornell University Medical College and as Medical Director of the New York Hospital, Westchester Division.

He is a staff consultant to a number of other general hospitals in the Westchester County area. Dr. Wall was graduated from the Jefferson Medical College of Philadelphia in 1927. He is a native of South Carolina.

Dr. Wall holds membership in the American Psychoanalytic Association, the American Psychiatric Association, the Association for Research in Nervous and Mental Disorders, and the American Psychopathological Association.

"Psychiatry for the General Practitioner" is the title of the paper to be presented by Dr. Wall before the General Session. As guest speaker of the Kentucky Psychiatric Association, he will discuss "Disturbances of Eating."

THOMAS J. E. O'NEILL, M.D.*

Philadelphia



Thomas J. E. O'Neill, M.D., a thoracic and cardiovascular surgeon in Philadelphia, was born in Baltimore, Maryland, in 1916. He received his Doctor of Medicine Degree from Ohio State University College of Medicine in 1940 and interned at West Baltimore General and City Hospitals.

He is a certified member of the American Board of Surgery and the Board of Thoracic Surgery. His medical school appointments include: Visiting Lecturer in Surgery, Graduate School of Medicine, University of Pennsylvania; Associate in Surgery, Woman's Medical College of Pennsylvania, and Associate Professor in Thoracic Surgery, Hahnemann Medical College, Philadelphia.

Dr. O'Neill is a member of numerous professional associations including the AMA, the American College of Chest Physicians, the International College of Surgeons, the National Tuberculosis Association, the American Heart Association and various city and state medical organizations. He is a founder member of the World Medical Association.

In addressing the General Scientific Session at the KSMA Annual Meeting, Dr. O'Neill will discuss "Surgical Treatment of Stenotic Valvular Diseases." His paper to be presented before the Kentucky Chapter of the American College of Chest Physicians will be "Surgery of Heart Other Than Stenotic Valvular Diseases."

WILLIAM BROMME, M.D.

Detroit



William Bromme, M.D., who was born in Louisville in 1906, is Chairman of the Council of the Michigan State Medical Society and serves on both the Blue Cross and Blue Shield Boards in Michigan. He is a former editor of the "Detroit Medical News."

Dr. Bromme has received three degrees from the University of Michigan, his A.B., M.D., and M.S. in surgery. At present he is Chief of the Section of Urology, Woman's Hospital, Detroit, and a Clinical Instructor in Urology, Wayne University College of Medicine.

Dr. Bromme is a founder member of the Detroit Surgical Association and the Detroit Surgical Society. He holds membership in numerous professional associations including the American College of Surgeons and the American Board of Urology.

In addition, Dr. Bromme is a Consultant in Urology at the Veterans' Hospital, Dearborn, Michigan; Associate in Urology, Grace Hospital, Detroit, and Surgeon at Harper Hospital, Detroit. He is a councilor for the Wayne County Medical Society. The title of Dr. Bromme's paper is, "Why the Urinary Antiseptics Fail."

MILTON C. COBEY, M.D.

Washington, D. C.



Milton C. Cobey, M.D., is Professor of Orthopedic Surgery at the Georgetown University Medical School and in charge of the Orthopedic Service for the Georgetown University-George Washington Services of the D. C. General Hospital for the resident training orthopedic program.

He was graduated from Duke University School of Medicine, Durham, North Carolina, in 1934 with graduate training for five years and residency in orthopedic surgery from 1934 to 1939 at Johns Hopkins Hospital, Baltimore, Maryland.

Dr. Cobey has been practicing orthopedic surgery in Washington, D. C. since 1939. He has spent four years in the United States Army Air Force as a consultant in his specialty. He holds membership in the American Academy of Orthopaedic Surgery, the American Board of Orthopaedic Surgery, and the American College of Surgeons.

He is a Consultant in Orthopedic Surgery for the U. S. Army and Air Force at Walter Reed Hospital. The title of Dr. Cobey's talk is "Low-Back Pain and Its Related Conditions — Particularly the Lumbar Disc."

House to Elect 5 Councilors at 2nd Session, Sept. 22

Five KSMA district councilors will be elected at the second session of the House of Delegates, Wednesday evening, September 22, at the Columbia Auditorium, Louisville, according to J. Farra Van Meter, M.D., Lexington, chairman of the Council.

Councilors will be elected for a three-year term in the following districts: 5th, 6th, 8th, 11th and 15th. Incumbent councilors, all of whom are eligible to succeed themselves, in these districts are:

Richard R. Slucher, M.D., Buechel—5th
L. O. Toomey, M.D., Bowling Green—6th
Edward B. Mersch, M.D., Covington—8th
Hugh Mahaffey, M.D., Richmond—11th
Edward Wilson, M.D., Pineville—15th

The method of selecting nominees for the office of district councilor is set forth in Chapter V, Section 6, of the KSMA By-laws. It reads:

"The Delegates from the counties in each Councilor District shall form the Nominating Committee for the purpose of nominating a Councilor for the Councilor District concerned. This committee shall hold a meeting open to all active members of the Councilor District concerned who are in attendance at the meeting for the purpose of discussing the nomination for the Councilor to serve the District. Additional nominations may be made from the floor by any member of the House of Delegates when the Nominating Committee makes its report to the House of Delegates."



Dr. Dallis

Creator of 'Rex Morgan' to Speak At President's Luncheon

Nicholas P. Dallis, M.D., Toledo, widely known to millions of newspaper readers by his pen name, Dal Curtis, creator of the non-comic strip, "Rex Morgan, M.D.," will be the featured guest speaker at the President's Luncheon, at 12 o'clock, Wednesday, September 22, 1954, in the Roof Garden, Brown Hotel, Louisville.

Lawrence Wetherby, governor of the Commonwealth of Kentucky, has accepted an invitation to attend the luncheon. In 1953, he signed Dr. Dallis' commission qualifying him as an Honorable Kentucky Colonel. Assisting the writer with his discussion will be several artists who will illustrate outstanding points of his talk on a drawing board.

A citation was presented to Dr. Dallis in recognition of the far reaching health educational service he performs by the American Medical Association during the 1954 Annual Meeting in San Francisco, in June. The AMA commended him for his contribution to public education on many medical subjects and particularly for alerting Americans to the dangers of medical quackery through an entertainment medium of widespread appeal.

In addition to being a writer-member of the team producing "Rex Morgan, M.D.," Dr. Dallis is engaged in the private practice of neuropsychiatry in Toledo and is a diplomate of the American Board of Neurology and Psychiatry. He was graduated from Temple University School of Medicine in 1938.

After practicing for one year in Pennsylvania he took a residency in neuropsychiatry at the Henry Ford Hospital in Detroit. After four years there he became director of the Toledo Mental Hygiene Center and consulting psychiatrist to the Juvenile Court. He resigned these two positions in 1950 in order to devote more time to his private practice.

Scientific Exhibits Present "Research in Plastics"

"Research in Plastics" is the title of one of the many excellent scientific exhibits that will be presented at the 1954 Annual Meeting of the KSMA, September 21, 22, and 23 at the Columbia Auditorium in Louisville, according to Everett L. Pirkey, M.D., Louisville, chairman of the Committee on Scientific Exhibits.

Milton Cobey, M.D., professor of orthopedic surgery at the Georgetown University Medical School, Washington, D.C., and one of the guest essayists, developed this exhibit which has to do with the use of plastics inside the body.

The Scientific Exhibits will be conveniently located, Dr. Pirkey said, in the two large rooms off the foyer at the Auditorium, immediately to the right after passing into the building through the main entrance. The space offers the members opportunity to study the exhibits in quiet and away from traffic.

Most of the exhibits to be presented this year were developed by KSMA members. Dr. Pirkey expressed regret that it was not possible to use all the material each year that was suggested. Lack of space was the reason given.

Special Bus Stop Established

A temporary bus stop will be established in front of the Columbia Auditorium as a special service to KSMA members, wives and their guests who are attending the Annual Meeting September 21, 22, and 23. Both north and south bound Fourth Street busses will accept and discharge passengers directly in front of the Auditorium during the meeting. This was made possible through special arrangements with the Louisville Transit Company.

OFFICIAL CALL

ANNUAL MEETING KENTUCKY STATE MEDICAL ASSOCIATION

To the officers and members of the component county societies of the Kentucky State Medical Association.

Meeting Place

The Annual Meeting of the Kentucky State Medical Association will convene at the Columbia Auditorium, Louisville, Tuesday, Wednesday, and Thursday, September 21-23, 1954. The General Session will be called to order at 9 a. m., Tuesday, September 21.

The House of Delegates

The first regular session of the House of Delegates will convene at 7 p. m., Monday, September 20; the second regular session will begin at 7 p. m., Wednesday, September 22. Both sessions will be held in the Columbia Auditorium.

Registration

The Registration Department will be open in the Columbia Auditorium from 6 p. m. to 8 p. m. on Monday, September 20; from 8 a. m. to 5 p. m. on Tuesday, September 21; from 8 a. m. to 5 p. m, and 6 p. m to 8 p. m. on Wednesday, September 22; and from 8 a.m to 5 p.m. on Thursday, September 23.

WOMAN'S AUXILIARY to the KENTUCKY STATE MEDICAL ASSOCIATION

Tuesday, September 21, Brown Hotel

Preconvention Board Breakfast, 9 a. m., South Room; Formal Opening of the Thirty-second Annual Meeting, 1 p. m., South Room.

Wednesday, September 22, Brown Hotel

Morning Session 9 a. m., South Room; Afternoon Session, beginning with a Subscription Luncheon and Style Show, 1 p.m., Crystal Ballroom.

Thursday, September 23, Brown Hotel

Subscription Breakfast and Post-Convention Board of Directors Meeting, 9 a.m., South Room.

Registration

The Registration Department of the Woman's Auxiliary will be open in the North Bay of the lobby, Brown Hotel, on Monday, September 20, from 12 Noon to 5 p.m.; Tuesday, September 21, from 9 a.m. to 5 p.m.; Wednesday, September 22, 9 a.m. to 11 a.m.

Regular Intervals Scheduled for Showing Scientific Movies

Special care has been taken by the Committee on Medical Education in selecting scientific movies to interest KSMA members and guests who will have the opportunity to see them during the Annual Meeting, according to Lawrence Minish, M.D., Louisville, chairman.

This year half-hour movies will be shown in the main auditorium of Columbia Auditorium under the able direction of Frank Shook, head of the Visual Aids Department of the University of Louisville.

Thirty minute movies are tentatively scheduled to be shown on Tuesday at 1:30 p.m., Wednesday at 8:30 a.m., Thursday at 8:30 a.m., and 1:30 p.m. Dr. Minish said that there would be subsequent announcements covering the development of the movie program.

Other committee members are: Harry Andrews, M.D., Louisville; Herbert L. Clay, Jr., M.D., Louisville; Joseph E. Hamilton, M.D., Louisville; Robert Lich, Jr., M.D., Louisville; Garnett J. Sweeney, M.D., Liberty; John C. Quertermous, M.D., Murray, and Allen L. Cornish, M.D., Lexington.

Visual Aids Provided

For the third consecutive year the visual aids equipment and assistance for the scientific essayists at the Annual Meeting will be provided by Mr. Frank Shook, head of the Department of Visual Aids at the University of Louisville School of Medicine.

Mr. Shook will be assisted by members of his competent staff. During the scientific sessions, a professional operator will be available at all times to aid the essayists in the visual presentation of their material, according to the Committee on Arrangements.

Annual Meeting to Memorialize 16th KSMA President


Dr. Thompson

The 1954 Annual Meeting of the Kentucky State Medical Association will memorialize J. W. Thompson, M.D., who served as the 16th president of the KSMA in the year 1874.

According to Emmet F. Horine, M.D., Brooks, historian for the association, in honoring Dr. Thompson, the KSMA is paying tribute to one of the earlier presidents of organized medicine in Kentucky's history.

It has been customary at each Annual Meeting since 1935 to memorialize a past president of the association or some distinguished Kentucky physician. Last year Lewis Rogers, M.D., 15th president of the association, was memorialized.

House to Elect 4 Officers at 1954 KSMA Annual Session

The following officers of the Kentucky State Medical Association will be elected by the House of Delegates, September 22, 1954, at the Columbia Auditorium in Louisville:

President-Elect
(from Western Section) 1 yr.
Vice-Presidents:
(from Eastern Section) 1 yr.
(from Central Section) 1 yr.
(from Western Section) 1 yr.
Delegates to AMA:
Delegate, (W. Clark Bailey, M.D., Harlan) 2 yrs.
Alternate, (Thomas V. Gudex, M.D., Louisville) 2 yrs.
(Incumbent officers listed in parentheses)

The offices of Orator in Medicine and Orator in Surgery are to be discontinued with the 1954 Annual Meeting as a result of By-Law changes in 1953. Election of officers will be held during the second session of the House of Delegates, Wednesday evening, September 22.

At the first meeting of the House, Monday evening, September 20, the Nominating Committee shall submit its report in writing to the House with one or more names for each officer to be elected. Additional nominations may be made from the floor at this time, the By-laws provide.

County Societies Urged to Certify Delegates to Hdq. Office

As the Journal goes to press, twenty Kentucky counties have not yet submitted the names of their official delegates to the 1954 Annual Meeting, September 21, 22, and 23, convening in Louisville, according to Charles A. Vance, M.D., Lexington, speaker of the KSMA House of Delegates.

Dr. Vance urges that these counties certify the names of their delegates to the Headquarters Office at the earliest possible date. According to the KSMA By-Laws, every county is entitled to at least one delegate, or a delegate for each 25 active members or major fraction thereof.

For the benefit of those counties who have not submitted the names of their delegates, we quote Chapter IV, Section 2 of the By-Laws:

"In the event there is no duly authorized delegate in attendance of the regular meeting of the House of Delegates the President shall consult any duly elected officer of the component society who is in attendance and with the approval of the Credentials Committee may appoint any active member of the component society in attendance at the meeting as the delegate. In the event there is no duly elected officer of the component society in attendance, the President may make the said appointment with the approval of the Credentials Committee. All appointments made shall also be with the approval of the House of Delegates."

A special bulletin board containing clippings of newsworthy KSMA members and projects during 1953 and 1954 will be a feature of the Education Campaign Committee Booth. This space is set aside especially for the physician's convenience. The individual in charge will take your order for any of the educational material available and be glad to discuss or answer any questions you may have. Tickets to the President's Luncheon may be purchased here.

Program

THE J. W. THOMPSON MEMORIAL MEETING

of the

KENTUCKY STATE MEDICAL ASSOCIATION

SEPTEMBER 21, 22, 23, 1954

LOUISVILLE

MONDAY, SEPTEMBER 20

3:00 P. M. Council Meeting.....Louis XVI, Brown Hotel

5:00 P. M. Council Dinner.....Louis XVI, Brown Hotel

6:00 P. M. Registration of House of Delegates.....Columbia Auditorium

7:00 P. M. First Meeting of House of Delegates.....Columbia Auditorium

TUESDAY, SEPTEMBER 21

8:00 A. M. Registration.....Columbia Auditorium

9:00 A. M Opening of the General Session.....Columbia Auditorium

9:30 A. M. First Scientific Session.....Columbia Auditorium

2:00 P. M. Second Scientific Session.....Columbia Auditorium

2:00 P. M. Reference Committee Meetings.....Columbia Auditorium

WEDNESDAY, SEPTEMBER 22

9:00 A. M. Third Scientific Session.....Columbia Auditorium

12:00 Noon President's Luncheon for Distinguished Guests Roof Garden, Brown Hotel

2:00 P. M. Specialty Group Meetings.....Columbia Auditorium

Replacing the regular general session will be eight specialty group meetings, which will be held simultaneously. Any KSMA member may attend any or as many of these meetings as desired. There will be four presentations in each group with 30-minute intermissions to view exhibits at 3:00 P. M

5:00 P. M. Council Dinner.....Louis XVI Room, Brown Hotel

6:00 P. M. Registration, House of Delegates.....Columbia Auditorium

7:00 P. M. Second Meeting, House of Delegates.....Columbia Auditorium

THURSDAY, SEPTEMBER 23

9:00 A. M. Fourth Scientific Session.....Columbia Auditorium

11:00 A. M. President's Address.....Columbia Auditorium

11:30 A. M. Presentation of Awards, Charge to New Members, Inaugural Ceremony, Presentation of Past-President's Key.....Columbia Auditorium

12:15 A. M Council Luncheon.....Parlors A, B, C, Brown Hotel

2:00 P. M. Fifth Scientific Session

A 30-minute intermission has been scheduled during each morning and afternoon Scientific Session for visiting the Scientific and Technical Exhibits.

SCIENTIFIC PROGRAM

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THE J. W. THOMPSON MEMORIAL MEETING

COLUMBIA AUDITORIUM

* * * *

THE KENTUCKY STATE MEDICAL ASSOCIATION

Tuesday, September 21

COLUMBIA AUDITORIUM

REGISTRATION

8:00 to 9:00 A. M.

OPENING OF GENERAL SESSION

9:00 A.M.

Call to Order by the President

J. Duffy Hancock, M.D., Louisville

Invocation

Rev. James Averitt, Louisville, Beachmont Methodist Church

Welcoming Remarks

David Cox M.D., Louisville, President, Jefferson County Medical Society

Announcements

Clyde C. Sparks, M.D., Ashland, President-Elect, Kentucky State Medical Association

Tuesday, September 21

FIRST SCIENTIFIC SESSION

9:30 A.M.

J. Duffy Hancock, M.D., Louisville, President, Presiding

9:30 Symposium on Physical Examination

Garnett J. Sweeney, M.D., Liberty, Moderator.

Participants in the Symposium are: Lungs, O. O. Miller, M.D., Louisville; Heart, Woodford B. Troutman, M.D., Louisville; Abdomen, Joseph E. Hamilton, M.D., Louisville; Neurology, Ralph J. Angelucci, M.D., Lexington, and Ob-Gyn, Anthony Giglia, Jr., M.D., Newport

10:30 Visit the Exhibits

11:00 Surgical Treatment of Stenotic Valvular Diseases

Thomas J. E. O'Neill, M.D., Philadelphia

11:30 Why the Urinary Antiseptics Fail

William Bromme, M.D., Detroit

12:00 ORATION IN MEDICINE

Cardiac Pain

Robert S. Dyer, M.D., Louisville

12:30 Lunch

Tuesday, September 21

COLUMBIA AUDITORIUM

SECOND SCIENTIFIC SESSION

2:00 P.M.

Robertson O. Joplin, M.D., Louisville, Vice-President, (Central), Presiding

2:00 Interpretation of Minimal Laboratory Procedures

A. J. Miller, M.D., Louisville

2:30 Obstetric Misconceptions

John Parks, M.D., Washington, D.C.

3:00 Visit the Exhibits

3:30 Psychiatry for the General Practitioner

James H. Wall, M.D., White Plains, N.Y.

4:00 Biopsy Panel

B. B. Holt, M.D., Ashland, Moderator.

Participants on the Panel are: Skin, George F. McAuliffe, M.D., Louisville; Breast, Jacob Mayer, M.D., Mayfield; Cervix, Jack C. Blackstone, M.D., Owensboro; Rectum, Rufus Alley, M.D., Lexington, and Bone Marrow, Everett H. Sanneman, Jr., M.D., Louisville.

4:30 Adjournment

Wednesday, September 22

COLUMBIA AUDITORIUM

REGISTRATION 8:00 to 9:00 A. M.

THIRD SCIENTIFIC SESSION

9:00 A.M.

Wyatt Norvell, M.D., New Castle, Vice-President (Eastern), Presiding

8:00 Visit the Exhibits

9:00 **Allergy in Infancy and Childhood**

Maurice Kaufmann, M.D., Lexington

9:30 **Treatment of Hyperthyroidism**

E. Perry McCullagh, M.D., Cleveland

10:00 **Visit the Exhibits**

10:30 **Immunization in Infancy and Childhood**

John C. Peterson, M.D., Milwaukee

11:00 **ORATION IN SURGERY**

Surgery of Trauma

John E. Haynes, M.D., Madisonville

11:30 **Adjournment**

PRESIDENT'S LUNCHEON

ROOF GARDEN—BROWN HOTEL

Tuesday, September 21

12:00 Noon

J. Duffy Hancock, M.D., President, Louisville, Presiding

Invocation

Rev. J. Richard O'Hare, Ph.D., Professor of Psychology, Bellarmine College, Louisville

Recognitions

J. Duffy Hancock, M.D.

Our Life with Rex Morgan

Nicholas P. Dallis, M.D., Toledo, Ohio, Creator of Illustrated Feature, 'Rex Morgan, M.D.'

Explanation of Wednesday Afternoon Programs

There will be no general session Wednesday afternoon. Instead, there will be eight specialty groups holding scientific meetings in the Columbia Auditorium simultaneously. The eight programs will follow the same schedule as the general session with half-hour presentations starting at 2:00 and 2:30 p.m., with a 30-minute intermission to visit exhibits at 3:00 p.m., with two more half-hour presentations starting at 3:30 p.m. Members of the Association will be free to move from one group meeting to another during these Wednesday afternoon sessions.

Kentucky Society of Anesthesiologists

2:00 **Post-Lumbar Puncture Headache**

Robert W. Lykins, M.D., Louisville

2:30 **Fluid Replacement Therapy in Surgical Procedures**

Fred M. Williams, M.D., Louisville

3:00 **Visit the Exhibits**

3:30 **Further Experiences with Hypotension During Surgical Procedures**

Curtiss B. Hickcox, M.D., Hartford, Connecticut

4:00 **Anesthesia for Pediatric Thoracic Surgery**

Robert P. Bergner, M.D., Louisville

4:30 **Adjournment**

Kentucky Chapter, American College of Chest Physicians

2:00 **Common Clinical Manifestations of Fungus Diseases**

Daniel N. Pickar, M.D., Louisville

2:30 **Surgery of Heart Other Than Stenotic Valvular Diseases**

Thomas J. E. O'Neill, M.D., Philadelphia

3:00 **Visit the Exhibits**

3:30 **Home and Office Treatment of Pulmonary Tuberculosis**

D. G. Miller, Jr., M.D., Morgantown

4:00 **Sanatorium Care of Tuberculosis**

Frank Stewart, M.D., Waverly Hills

4:30 **Adjournment**

Kentucky Chapter, American Academy of General Practice

2:00 **Medical Management of the Complicated and Uncomplicated Duodenal Ulcer**

John F. Ganem, M.D., Louisville

2:30 **Gout**

Robert L. McClendon, M.D., Louisville

3:00 **Visit the Exhibits**

3:30 **Hernia in Children**

Ralph M. Larsen, M.D., Nashville

4:00 **Office Proctology**

Marvin A. Lucas, M.D., Louisville

4:30 **Adjournment**

Kentucky Obstetrical and Gynecologic Society

2:00 **Vaginal Hysterectomy**

Samuel S. Gordon, M.D., Louisville

2:30 **Present Status of the Rh Factor**

Glenn Bryant, M.D., Louisville

3:00 **Visit the Exhibits**

3:30 Operative Obstetrics

John Parks, M.D., Washington, D.C.

4:00 Etiology and Incidence of Foetel Anomalies

Joseph Spaulding, M.D., Paducah

4:30 Adjournment

Kentucky Chapter, American Academy of Pediatrics

2:30 BCG Vaccination

John C. Peterson, M.D., Milwaukee

3:00 Visit the Exhibits

3:30 Congenital Heart Disease

Alex J. Steigman, M.D., Louisville, Moderator.

Participants are: Samuel Kaplan, M.D., Cincinnati; Hugh Lynn, M.D., Louisville; I. Diamond, M.D., Louisville, and Everett L. Pirkey, M.D., Louisville.

4:30 Adjournment

Kentucky Chapter, American College of Physicians

2:00 Carbohydrate Metabolism

James Robert Hendon, M.D., Louisville

2:30 Differential Diagnosis of Pituitary Tumors

E. Perry McCullagh, M.D., Cleveland

3:00 Visit the Exhibits

3:30 The Mode of Action of Chemotherapeutic and Antibiotic Agents

Wallace E. Herrell, M.D., Lexington

4:00 Management of the Anuric Patient

William Brodsky, M.D., Louisville

4:30 Adjournment

Kentucky Psychiatric Association

2:00 Follow-up Studies on the Grantham Type Lobotomy

Louis M. Foltz, M.D., Louisville

2:30 Disturbances of Eating

James H. Wall, M.D., White Plains, N.Y.

3:00 Visit the Exhibits

3:30 Some Aspects of the New Mental Health Law

Frank M. Gaines, M.D., Louisville

4:00 Chronic Alcoholic Intoxication, an Experimental Study of the Etiology of Delirium Tremens

Abraham Wikler, M.D., Lexington

4:30 Adjournment

Southeastern Surgical Congress

2:00 The Groin Dissection for Malignancy

Robert Tate, M.D., Louisville

2:30 Inter-relationship Between GP and Surgeon

C. Walker Air, M.D., Ludlow

3:00 Visit the Exhibits

3:30 Pitfalls in Gall Bladder and Common Duct Surgery

Philip Thorek, M.D., Chicago

4:00 Surgical Management of Cancer of the Colon and Rectum

Coleman C. Johnston, M.D., Lexington

4:30 Adjournment

Wednesday, September 22

COLUMBIA AUDITORIUM

REGISTRATION OF DELEGATES

6:00 to 7:00 P.M.

7:00 SECOND MEETING OF THE HOUSE OF DELEGATES

(All members are privileged to attend)

Thursday, September 23

COLUMBIA AUDITORIUM

REGISTRATION 8:00 to 9:00 P.M.

FOURTH SCIENTIFIC SESSION

9:00 A.M.

Leon Higdon, M.D., Paducah, Vice-President (Western), Presiding

9:00 Low Back Pain and Its Related Conditions—Particularly the Lumbar Disc

Milton Cobey, M.D., Washington, D. C.

9:30 Socialized Dentistry and Its Relation to Children

Raymond E. Myers, D.D.S., Louisville

10:00 Visit the Exhibits

10:30 Hashimoto's Disease

Ralph M. Larsen, M.D., Nashville

11:00 President's Address

J. Duffy Hancock, M.D., Louisville, KSMA President

11:30 Presentation of Awards

Bruce Underwood, M.D., Secretary and General Manager, KSMA

Charge to New Members

Clyde C. Sparks, M.D., President-elect

Inaugural Ceremony

Presentation of Past-President's Key

11:45 Plastic Surgery

John C. Weeter, M.D., Louisville

12:15 Lunch

Thursday, September 23

COLUMBIA AUDITORIUM

FIFTH SCIENTIFIC SESSION

2:00 P.M.

Clyde C. Sparks, M.D., Ashland, President, Presiding

2:00 Bronchiectosis

William C. Hambley, M.D., Pikeville

2:30 Recommended Expansion of Interests in Anesthesiology

Curtiss B. Hickcox, M.D., Hartford, Connecticut

3:00 Visit the Exhibits

3:30 Diagnosis and Treatment of Diseases of the Breast

Philip Thorek, M.D., Chicago

4:00 Symposium on X-Ray Interpretation

Robert M. Coleman, M.D., Hopkinsville, Moderator.

Participants are: Abdomen, Edward Maxwell, M.D., Louisville; Skeleton System, Leslie Urban, M.D., Ashland; and Chest, Alfred Miller, M.D., Louisville.

4:30 Adjournment

Carefully selected scientific movies of general interest will be shown at thirty minute intervals sandwiched between the regular scientific sessions. The main auditorium will be used as a theatre where motion pictures will be operated expertly by members of the University of Louisville Visual Aids Department. All movies to be shown have been carefully selected and reviewed by the Committee.

THIRTY-SECOND ANNUAL MEETING

of the

WOMAN'S AUXILIARY

to the

Kentucky State Medical Association

BROWN HOTEL

Louisville, Kentucky

September 21, 22, 23, 1954

REGISTRATION:

North Bay of Lobby, Brown Hotel

Monday—12 Noon to 5 p.m.

Tuesday—9 a.m. to 5 p.m.

Wednesday—9 a.m. to 11 a.m.

Chairman of

Registration.....Mrs. J. O. Mattox
Carrollton

Tuesday, September 21

9:00 a. m.

South Room

Preconvention Board Breakfast (subscription). (The Board consists of all general state officers, councilors, state committee chairmen, county auxiliary presidents, and three immediate past presidents.)

Tuesday, September 21

1:00 p. m.

South Room, Brown Hotel

Formal opening of the Thirty-second Annual Meeting of the Woman's Auxiliary to the Kentucky State Medical Association.

Presiding.....Mrs. Clyde C. Sparks
Ashland, President

Invocation.....Mrs. Clark Bailey
Harlan

Pledge of Allegiance
to the Flag.....Mrs. Samuel H. Flowers
Middlesboro

Pledge of Loyalty.....Mrs. Flowers
"I pledge my loyalty and devotion to the American Medical Association. I will support its activities, protect its reputation, and ever sustain its high ideals."

Address of Welcome.....Mrs. Earl W. Roles
Louisville, President
Jefferson County Auxiliary

Response.....Mrs. David Woolfolk Barrow
Lexington, Immediate Past President

In Memoriam.....Mrs. Garland Clark
Winchester, Councilor of District 11

Presentation of Convention
Chairman.....Mrs. J. Andrew Bowen
Louisville

Roll Call.....Mrs. William Cartmell
Maysville

Minutes of the Thirty-first
Annual Meeting.....Mrs. Cartmell

Report of the 1954 National Convention

REPORTS OF OFFICERS:

Treasurer.....Mrs. William Cloyd
Richmond

President-Elect and Organization
Chairman.....Mrs. Karl D. Winter
Louisville

President.....Mrs. Clyde C. Sparks

Old Business

New Business

Report of Nominating
Committee....Mrs. David Woolfolk Barrow
Chairman

Election of Nominating Committee, 1954-1955

Presentation of 1954-1955
Budget.....Mrs. A. B. Colley
Calhoun, Finance Chairman

Report of Registration.....Mrs. J. O. Mattox

Reports of County Auxiliary Presidents

Reports of State Chairmen

3:30 p. m.

Informal Tea, Louis XVI Room

(All doctors' wives invited)

Wednesday, September 22

9:00 a. m.

South Room

Reading of Minutes....Mrs. William Cartmell

Roll Call.....Mrs. Cartmell

Announcements.....Mrs. J. Andrew Bowen
Convention Chairman

Address.....J. Duffy Hancock, M.D.
Louisville, President, KSMA.

Old Business

New Business

Election of Officers

Presentation of Distinguished Guests
Mrs. George Turner, El Paso, Texas, President, Woman's Auxiliary to the American Medical Association.
Mrs. George D. Feldner, New Orleans, President, Woman's Auxiliary to the Southern Medical Association.

Address.....Mrs. George D. Feldner

Installation of Officers..Mrs. George Turner

Inaugural Address.....Mrs. Karl D. Winter

Announcement of Committee
Chairmen.....Mrs. Winter

Final Report of Registration.....Mrs. Mattox

Adjournment

Wednesday, September 22

1:00 p. m.

Crystal Ballroom

Subscription Luncheon

Style Show in Honor of

Mrs. George Turner and Mrs. George D. Feldner

Invocation.....Mrs. P. E. Blackerby
Parliamentarian, Louisville

Presentation of Officers

Presentation of Distinguished Guests

Address.....Mrs. George Turner
President, Woman's Auxiliary to the
American Medical Association

Style Show

Wednesday, September 22

South Room

Conferences of State Committee Chairmen with County Auxiliary Committee Chairmen

Thursday, September 23

9:00 a. m.

South Room

Board Breakfast (subscription) and Meeting
Mrs. Karl D. Winter, Presiding

STATE CONVENTION COMMITTEES

General Chairman.....Mrs. J. Andrew Bowen
Louisville

Registration.....Mrs. J. O. Mattox
Carrollton

Style Show Luncheon....Mrs. Parmell Rollings
Louisville

Hospitality and Hospitality
Room.....Mrs. John B. Floyd, Jr.
Lexington

Publicity.....Mrs. Arthur M. Schoen
Louisville

Flowers.....Mrs. Robert F. Monroe
Louisville

WOMAN'S AUXILIARY TO THE KENTUCKY STATE MEDICAL ASSOCIATION

1953 - 1954

State Officers

President: Mrs. Clyde C. Sparks, Ashland
President-Elect: Mrs. Karl D. Winter, Louisville
Vice-President: Mrs. R. W. Bushart, Fulton
Vice-President: Mrs. J. O. Mattox, Carrollton
Vice-President: Mrs. Tracy Doty, Pikeville
Vice-President: Mrs. William McCormack, Bowling Green
Recording Secretary: Mrs. William Cartmell, Maysville
Corresponding Secretary: Mrs. Duane Jones, Ashland
Treasurer: Mrs. William Cloyd, Richmond
Parliamentarian: Mrs. Phillip E. Blackerby, Louisville

Advisory Committee

Karl D. Winter, M.D., Louisville, Chairman
Albert S. Warren, M.D., Lexington
R. Ward Bushart, M.D., Fulton

Immediate Past Presidents

Mrs. Clark Bailey, Harlan
Mrs. John Harter, Louisville
Mrs. David Woolfolk Barrow, Lexington

District Councilors

1st—Mrs. Vernon Pace, Paducah
2nd—Mrs. Walter L. O'Nan, Henderson
3rd—Mrs. R. E. Davis, Central City
4th—Mrs. J. M. Dishman, Greensburg
5th—Mrs. J. Andrew Bowen, Louisville
6th—Mrs. Arthur D. Donnelly, Jr., Bowling Green
7th—Mrs. H. V. Stewart, Carrollton
8th—Mrs. Carl Pieck, Covington
9th—Mrs. J. E. McKinney, Maysville
10th—Mrs. John Prewitt, Lexington
11th—Mrs. Garland Clark, Winchester
12th—Mrs. Robert Bateman, Danville
13th—Mrs. Charles B. Johnson, Russell
14th—Mrs. T. M. Perry, Jenkins
15th—Mrs. Charles Stacy, Pineville

Committee Chairmen

American Medical Education Foundation: Mrs. Keith Smith, Corbin
Benevolence: Mrs. Lyman Hall, Campbellsville
Blue Grass News: Mrs. E. W. Jackson, Paducah
Bulletin: Mrs. B. Earl Caywood, Danville
Cancer: Mrs. Irving Gail, Lexington
Civil Defense: Mrs. Victor Paul Dalo, Louisville
Doctor's Shop: Mrs. Carroll Price, Harrodsburg
Finance: Mrs. A. B. Colley, Calhoun
Heart: Mrs. Claud Bays, Lexington
Historian: Mrs. Phillip E. Blackerby, Louisville
Legislation: Mrs. Clark Bailey, Harlan
McDowell House: Mrs. Walker Owens, Mt. Vernon
Mental Health: Mrs. Robert Lehman, Louisville
Nominations: Mrs. David Woolfolk Barrow, Lexington
Nurse Recruitment: Mrs. G. B. Froage, Paducah
Program: Mrs. J. E. Glauber, Carrollton
Public Relations: Mrs. John Dunn Gordinier, Louisville
Revisions: Mrs. E. Lee Heflin, Louisville
Rural Health: Mrs. Garnett Sweeney, Liberty
Today's Health: Mrs. B. T. Harris, Lexington
Tuberculosis: Mrs. C. I. Haeberle, Russell

PROPOSED AMENDMENTS

to the

CONSTITUTION AND BY-LAWS

of the

WOMAN'S AUXILIARY

to the

KENTUCKY STATE MEDICAL ASSOCIATION

The Constitution

Art. VII Sec. 1 "c"—add, "appointive and special" after the word, "standing."

Art. IX Sec. 1—add "appointive and special" after the word, "standing."

By-Laws

Art. IV Sec. 15—A new section to be numbered "15". "The program committee shall outline a program of activities for the county chairmen of program based on recommendations from the national chairman of program and this outline shall have the approval of the president." Sections 15, 16, 17 and 18 to be renumbered.

Art. VIII Sec. 1—"a" add after "Auxiliary," the phrase, "or the President-Elect in the absence of the President."

The KSMA Headquarters Office will be located for the first time on the south side of the balcony overlooking the Technical Exhibit Hall.



An invitation is extended to all KSMA members to bring their golf clubs to Louisville and participate in the 1954 Annual KSMA Golf Tournament, to be held at Audubon Country Club, September 20, 21, 22, and 23. Make plans now to get in the swing and enjoy the good fellowship and sport offered.

Audubon Country Club Is Site OF KSMA Golf Tournament

Audubon Country Club in Louisville will be the site of the KSMA Golf Tournament to be held in conjunction with the Annual Meeting, according to Clifton G. Follis, M.D., Glasgow, chairman of the Golf Committee.

KSMA physicians and their guests may participate in play Monday , Tuesday, Wednesday, or Thursday, September 20 through 23, Dr. Follis stated. However, only the first day of play of any member will count in the contest for tournament prizes, in accordance with a decision of the Golf Committee.

Believing that it is desirable to put the annual golf tournament on a more stable footing, the committee is organizing the KSMA Golf Association. Dr. Follis urged all who are interested in playing golf during the annual meeting to send their membership fee of $5.00 to his committee at the Headquarters Office, 620 S. Third Street, Louisville. At that time members should state tentatively what day they expect to play.

It was pointed out that payment of these fees would enable the committee to organize a far more enjoyable tournament and to make a more attractive offering of trophies.

It is expected that two traveling golf trophies will be presented this year. One of these will be for an all-age low net champion and a similar one for senior members only (50 years and older). The Golf Committee plans to have the trophies displayed in a case in the Technical Exhibit Hall at the Columbia Auditorium with information and each day's winners posted.

Other members on the Golf Committee are Robert Long, M.D., Louisville, who is in charge of arrangements; Joseph R. Humpert, M.D., Covington; Sam A. Overstreet, M.D., Louisville, and William C. Wolfe, M.D., Louisville.

AAGP Allows Credit Hours

KSMA members who are also members of the Kentucky Academy of General Practice will be allowed hour for hour credit for attending the scientific sessions of the Annual Meeting in Louisville, September 21, 22, and 23. These hours are applicable to the 100 credit hours to be obtained in three years and not considered part of a planned formal course.

Ky. Chapter of ACS to Meet Sept. 20, Louisville

The Kentucky Chapter of the American College of Surgeons will hold a meeting Monday, September 20, in the Crystal Ballroom of the Brown Hotel, Louisville, prior to the Annual Meeting of the KSMA, September 21-23, according to J. C. Drye, M.D., Louisville, secretary of the Kentucky chapter.

Scheduled first for the all day meeting is an outstanding scientific program beginning at 10 a.m., followed by a luncheon at noon and an afternoon business session from 2:00 to 4:30 p.m. Paul Hawley, M.D., Chicago, director of the American College of Surgeons, is the out-of-state guest luncheon speaker who will discuss various aspects of "Chapter Activities."

John C. Burch, M.D., Nashville, president of the Southern Surgical Association and professor of Gynecology at Vanderbilt University School of Medicine, will present a paper entitled "Complications of Hysterectomy" at the morning scientific session.

"The Surgical Importance of the Internal Mammary Nodes in Breast Cancer" is the topic of Jerome A. Urban, M.D., of Memorial Hospital, New York. A third speaker on the scientific program is William Bromme, M.D., Detroit, Michigan, who will discuss "Injuries to the Uro-Genital Tract."

In addition, Hugh B. Lynn, M.D., assistant professor of the University of Louisville School of Medicine, will present a paper before the group, Dr. Drye said.

You Can Be Reached at Annual Meeting Thru WA 6903

WAbash 6903 for the fifth straight year, will be the Special KSMA Annual Meeting telephone number, September 20, 21, 22 and 23, at the Columbia Auditorium in Louisville.

Be sure to leave this number with your patients, office or residence if you wish to be reached while attending the Annual Sessions.

This phone, which is for incoming calls only, is made possible through special arrangements with the Southern Bell Telephone Company and the Columbia Auditorium. Members may make out bound calls at any of the four booths conveniently located near the main entrance of the building.

New Ideas, Products to be Seen Among 61 Technical Exhibitors

New ideas, new information, new equipment presented by experts from the medical manufacturing and service industries will be on hand to serve you in the Technical Exhibit Hall at the Columbia Auditorium during the KSMA Annual Meeting, September 21, 22, and 23.

Sixty-one organizations, which are contributing a worthy share to the art of healing and are demonstrating the industry's effective effort to provide the needs of modern medicine, have purchased all available Technical Exhibit space at our meeting.

"Each KSMA member attending the 1954 Annual Sessions will find his time both profitably and pleasantly spent by visiting the booths of our exhibitors," Carlisle R. Petty, M.D., Louisville, chairman of the Technical Exhibits Committee, said.

The Technical Exhibit Hall will be open Tuesday and Wednesday, September 21 and 22 from 8:00 a.m. to 5:30 p.m. and on Thursday, September 23 from 8:00 a.m. to 3:30 p.m. In addition, a 30-minute intermission is provided each morning and each afternoon during the three day sessions. All companies exhibiting in the hall have had products approved by an appropriate council of the AMA.

Chairmen Announced for Three U. of L. Class Reunions

Chairmen of University of Louisville School of Medicine class reunions for the years 1924, 1944 and 1949, to be held during the Annual Meeting of the KSMA, September 21-23, have been announced through the office of Leslie Shively, director of Alumni Relations for the University of Louisville.

The chairmen are:

Stanley T. Simmons, M.D., Louisville—1924.

Arthur H. Keeney, M.D., Louisville—1944

Charles N. Floyd, M.D., Louisville—1949.

In addition, three other classes, 1909, 1914 and 1934 will hold reunions during the Annual Meeting. If you are a member of any of these graduating classes, you can look forward to being reunited with many of your former classmates.

Hazards of Blood Transfusions

With Illustrative Fatal Cases*

EVERETT H. SANNEMAN, Jr., M.D.**

Louisville

The formation of a National Blood Bank program during World War II and its subsequent continuation has changed the use of blood from a purely local procedure to a large scale, national, or international business. In 1952 4,193,000 units of whole blood were processed in the United States as compared to 3,000,000 units in 1949. The need has continued to grow so that for 1953, the American Red Cross collected about 5,000,000 pints of blood to meet this need[1]. This increase in the use of blood is reflected in the Louisville area as illustrated in Figure 1.

This increase in the use of blood has been a mixed blessing. No one will question the fact that the more frequent use of blood has saved many lives where formerly people died because blood was not available. However, the use of blood has been abused in many instances too, and blood given in situations where it is not indicated. This nonchalant use of blood should be viewed with great concern since blood transfusions have a higher mortality rate than an appendectomy or an ether anesthetic[2]. Indeed, the mortality from blood transfusions has been estimated at one death in every 1000-3000 transfusions[3].

It is the purpose of this paper to discuss some of the more severe types of transfusion reactions, to present illustrative fatal cases, and then to outline precautionary measures which are designed to reduce these risks.

Seven types of transfusion reactions can occur. They are: (a) febrile reactions, (b) anaphylactic reactions, (c) air embolism, (d) transmission of disease, (e) bacterial contamination, (f) circulatory overloading, and (g) hemolytic reactions caused by incompatible blood.

The first two, febrile and anaphylactic reactions, are relatively mild and very rarely cause death. Air embolism need not be discussed here since pressure transfusions are not widely used in this area. This leaves then four major types of reactions which can be serious.

Transmission of Disease

The various diseases transmitted from the donor to the recipient by blood transfusions range from the common ones such as measles, influenza[4], malaria[5], syphilis[6], and homologous serum hepatitis[7] to rare ones such as Chagas' disease[8]. Measles and influenza have occurred when the donor gave blood while he had one of these diseases in the prodromal stage.

Careful attention must be given to the malaria question in interviewing prospective donors. This problem is even more serious when one realizes the great number of Korean War veterans now back in the general population, many of whom have not had clinical malaria because of suppressive treatment while in the endemic areas. Donors with even a questionable history of malaria during the preceding five years should either be rejected or have their donation used for plasma.

The control of the transmission of syphilis is much easier. It has been shown that if blood is refrigerated for 96 hours the Treponema pallidum become avirulent[9]. Therefore, syphilis can only be transmitted by blood which has been drawn within three days before the time it is given. If one were to take the time and perform serologic tests of these bloods,

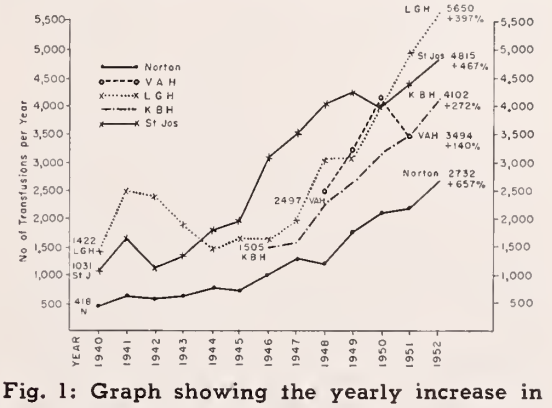


Fig. 1: Graph showing the yearly increase in the number of blood transfusions given in 5 Louisville Hospitals (Norton Memorial Infirmary, Veterans Administration Hospital, Louisville General Hospital, Kentucky Baptist Hospital, and St. Joseph Infirmary). Percentage figures refer to percent increase of 1952 over first year figure for each respective hospital.

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the transmission of syphilis by this method could be eradicated.

Homologous serum hepatitis came to the fore during World War II when large quantities of pooled dried plasma were being used. This disease, which is caused by a virus, has an incubation period varying from one to as long as six months. Because of this long lapse of time, the patient presenting himself with this disease may have entirely forgotten about any transfusion unless he is questioned about it specifically. Since the disease is more common when pooled plasma is used, it stands to reason that its incidence can be greatly reduced by the use of smaller pools, or of individual donors for making the plasma.

Moore states that homologous serum hepatitis occurs in one out of every 200 transfusions and caused one death in every 6000 transfusions[3]. It was once thought that ultraviolet irradiation of dried plasma would destroy the causative agent of homologous serum hepatitis[10]. However, it has been shown more recently that this procedure is not reliable. In one series, 12.8% of the patients who received pooled, dried, irradiated plasma developed serum hepatitis, and 30.5% of these died as a result of the disease[11].

Since this disease is so serious great care must be used in recruiting donors. They should be questioned not only about any history of jaundice, but also about being in contact with anyone else who was jaundiced. If the answer to either of these questions is in the affirmative, the prospective donor should be rejected. While this may seem over-strict, actually only 2% of 199,820 donors were rejected because of these reasons[12].

Case Report

J. H., a 75 year old white widower entered the hospital with a Grade III benign enlargement of the prostate. A retropubic prostatectomy was performed, during which procedure the patient received two pints of blood. He was discharged one week later after an uneventful recovery. Three months later he was readmitted in a comatose state. The skin and sclera were markedly icteric. There was a subconjunctival hemorrhage in the left eye. There was fresh blood in the perianal region. Serum bilirubin was 28.2 mgm.% and prothrombin time was 9%. In spite of supportive treatment, the patient died less than 36 hours after admission. Autopsy revealed severe homologous serum hepatitis and an acute purulent bronchial pneumonia.

The relatively long incubation time of homologous serum hepatitis is well illustrated in this case. Here the period between the time of transfusion and occurence of symptoms was three months. The malignant nature of this disease is quite apparent here too. It would be interesting to review the donor's registration cards and check the answers to the questions relating to jaundice. One must realize that some donors in their enthusiasm to give blood may falsify some answers if they thought they might be rejected. While such enthusiasm is praiseworthy, it does not justify the fatal or near-fatal complications which may result from falsification of answers.

Bacterial Contamination

Bacterial contamination of blood after it has been drawn from the donor is another hazard associated with blood transfusions. Transfusion reactions and even deaths have resulted from bacterial contamination[13] and from bacterial toxins[14] in stored blood. There are many ways in which blood can become contaminated from the time it leaves the donor until the recipient receives it. Faulty or incomplete cleansing of the donor's arm, contamination of tubing or collecting bottles, faulty caps on bottles, improper refrigeration, or entry of the bottle to obtain a blood specimen for laboratory testing are a few of the portals of entry for harmful bacteria.

In attempting to prevent this contamination, nurses or technicians in blood banks should be rigorously schooled in technique, and should not be given other duties so that their technique becomes careless and haphazard.

Pilot tubes containing a specimen of the blood in the larger bottles are supposed to be with every unit of blood. The blood in these tubes is to be used to run all the tests necessary to prepare the blood for the patient. Occasionally the pilot tube becomes lost and some well-meaning technician breaks a rule of the National Institute of Health and takes a specimen from the large bottle. This invites the hazard of bacterial contamination, and any bottle handled thusly should not be used for transfusion purposes.

One should not forget the process of continuous refrigeration for blood. Any

procedure in which the blood is kept out of the ice-box for a long period of time invites the growth of bacteria. Unfortunately some bacteria can grow even at ice-box temperature[13] so one must not be lulled into a false sense of security just because continuous refrigeration has been employed.

Bacterial contamination can usually be detected by the presence of hemolysis in the plasma. Therefore, every bottle of blood should be carefully examined for hemolysis before the cells are resuspended in their own plasma just prior to starting the transfusion. Here again though, some of the bacilli which grow at low temperatures do not produce macroscopic hemolysis so one must not feel too secure just because the plasma appears normal.

Patients who receive contaminated blood usually show symptoms of profound peripheral vascular collapse from which they may or may not recover.

Case Report

M. C., a 37 year old while female, 7½ months pregnant, entered the hospital because of weakness, anemia, and vaginal spotting. Physical examination was not remarkable. Laboratory studies revealed a red count of 3.82 million with 10.5 grams of hemoglobin. She received 500 cc. of AB, Rh positive blood uneventfully the day after admission. On the following day, a second transfusion of AB, Rh positive blood was started. Fifteen minutes later she complained of her arm hurting. The blood was discontinued immediately, only about 50-60 cc. having been given. Her blood pressure dropped to 90/60 and later to 70/50 and remained there. She complained of pain in the back and legs; her face was flushed. Her temperature rose to 103.4 in five hours. She was placed in an oxygen tent, digitalized and given intravenous fluids. She later became cyanotic with a faintly jaundiced tinge. Despite all supportive measures her blood pressure fell to 50/20 and she died quietly 24 hours after the second transfusion was started.

The blood which produced the reaction in this case was type AB, positive for Rh-D, and negative for Rh-C and E. The bottle had been obtained from the Red Cross eight days before its expiration date. On that same day, the blood was cross-matched for another patient, and the pilot tube was removed. At approximately 11:00 A. M., five days later on the morning of the ill-fated transfusion, the blood was again removed from the ice-box. Since the pilot-tube could not be found, the metal band securing the rubber stopper was removed, and with a sterile needle and syringe, 5 cc. of blood were removed for cross-matching. At this time it was not definitely noted whether or not there was any hemolysis. The blood was returned to the refrigerator where it remained until 1:15 P.M. when it was taken to the patient's room. Following the reaction the blood was retyped and recross-matched on two different occasions by two different technicians and still found to be compatible. Direct and indirect Coombs tests were negative. Twenty-seven hours after the transfusion had been started, blood was removed from the bottle for smear and culture. At this time considerable hemolysis was noted. A direct smear revealed numerous clumps of bacilli, which in culture were identified as Clostridium histolyticum.

It would be impossible to find the time at which this blood became contaminated. It would seem unlikely though that it was contaminated by the technician entering the bottle only 2½ hours before the blood was given. Nevertheless, this technique was contrary to the N.I.H. regulations as stated above, and could serve as the portal of entry for the pathogens.

It must be remembered that bacterial contamination is not a rarity. In one series, 38 out of 1687 pints of blood, or 2.24%, grew positive cultures[15]. This fact should be kept in mind by everyone who has anything to do with processing and handling of blood.

Circulatory Overloading

Circulatory overloading refers to that condition in which the blood volume is increased too rapidly for the patient to adjust to the increase. It is well to remember that there are many causes for anemia. If it is caused by acute blood loss, the total blood volume is lowered. In this condition one can administer blood as fast as it is being lost in order to combat signs of shock and maintain an adequate blood volume. However, in anemia of chronic blood loss, chronic infection, or chronic debilitating states, the blood volume may be only slightly decreased. If this is so, one may quite easily overload the circulatory system by giving too much blood too rapidly. This is easier to do in cardiac patients or elderly patients with poor cardiac reserve. One must be very cautions in transfusing these patients and the rate should not ex-

ceed forty drops a minute[16]. At this rate it should take between three and four hours to give a 500 cc. transfusion.

When blood is given too rapidly and/or in too great a quantity, there is a rise in venous pressure and a diminution in vital capacity by engorgement of the pulmonary circulation. This produces tightness in the chest, dyspnea, a dry cough, and a feeling of fullness in the head. If these signs and symptoms are ignored and the transfusion continued, frank pulmonary edema will ensue. There is a good chance that the appearance of some of these symptoms has in the past been misinterpreted as hemolytic or allergic reactions, and the gravity of the situation missed. If circulatory overloading is suspected, the transfusion should be stopped immediately. Actual phlebotomy should be practiced if the patient's symptoms do not subside.

The person who is responsible for watching the patient while he is receiving a transfusion, whether he be doctor, house-officer, or nurse, should observe these patients carefully and be ready to stop the transfusion at the first symptom.

This problem is even more serious in surgical patients because the symptoms are masked by the anesthesia. In this situation the patient can be quite easily drowned without the least tell-tale sign. This subject of blood transfusions during surgical procedures brings up the question of exactly how much blood surgical patients should receive while on the operating table. Saltzstein and Linkner[17] have studied blood loss during operations and suggest that surgeons acquaint themselves with how much blood is usually lost during different operative procedures. This is a most timely suggestion since our "medical or surgical judgment" regarding blood loss is sometimes quite misleading.

Case Report

B. K., a 67 year old executive with chronic monocytic leukemia was admitted to the hospital for blood transfusions. Physical examination revealed a dyspneic, chronically ill man. The liver was enlarged five finger breadths and the spleen was enlarged four finger breadths. There were petechiae over the lower extremities. His red blood count was 2.76 million with 8.5 grams of hemoglobin.

A transfusion of 500 cc. of blood was given on the day of admission in 2½ hours, and 500 more cc. were given the following day in one hour and 45 minutes. One hour after discontinuing the transfusion he complained of dyspnea. Later he began coughing and became cyanotic. He was placed in an oxygen tent, and given intravenous aminophyllin. He continued to be dyspneic and apprehensive, restless and confused. Despite enthusiastic supportive therapy, including digitalization, he continued in much the same situation for the next two weeks. A chest x-ray showed a dilated heart with pulmonary edema and pulmonary congestion. Several small transfusions were given slowly. Two weeks after his admission, 125 cc. of blood were given in one hour and 45 minutes. One hour later he became more nervous and complained of heart pain. He became clammy and spit up bloody mucus. His apprehension and confusion increased and he died on the following day.

This patient was in a precarious cardiovascular balance as evidenced by his chronic disease, his anemia, and his symptoms of dyspnea. There was little doubt that the rapid rate at which the first two transfusions were given this patient on his last hospital admission produced a state of irreversible pulmonary edema, and cardiac decompensation.

Hemolytic Reactions

While transmission of disease, bacterial contamination, and circulatory overloading can each be dangerous and fatal in their own right, by far the greatest danger in blood transfusions is found in hemolytic reactions due to incompatibility. This danger has been made more evident in the past several years by the discovery of more minor blood groups. These minor blood groups include the MNS systems, the Kell, Duffy, Kidd, P, Lewis, and Lutheran systems. Since all these different blood groups have been isolated it has been estimated that there are about 631,800 possible numbers of genotypes that can result from them[18]. Furthermore, it has been stated that 80% of all transfusions are potentially a risk due to antigenic substances in the donor blood not possessed by the recipient[19].

The A, B, and D groups are the main offenders in hemolytic transfusion reaction, being responsible for 95% of all incompatible reactions. For one to have a reaction to any of the minor groups one must have been previously exposed to that group in order to develop circulating antibodies. This can be accomplished by one of two

methods; by previous pregnancies, or by previous transfusions.

It should then be part of the pre-transfusion routine to check for the presence or absence of these circulating antibodies. The standard cross-match, of course, determines compatibility in the ABO system. Determination of the Rh factor should avoid incompatibilities from this source. It then remains to determine whether or not there are any circulating antibodies to the other blood groups. It has become a practice of many hospitals now to perform a Coombs cross-match test on donor's cells and patient's serum in order to detect any minor blood group incompatibility. One must be careful in doing this test since the use of a non-potent Coombs serum might lead to serious error. Controls should be run with every new batch of Coombs serum received by the laboratory to check its potency.

Anyone who associates himself with blood transfusions should be aware of the signs and symptoms of a hemolytic transfusion reaction. These may include burning in the arm, flushing of the face, chills and fever, substernal pain, lumbar pain, leg cramps, nausea and vomiting, and hypotension. All or none of these signs may be present, and they of course can be masked by anesthesia.

When starting a transfusion one should observe the patient carefully at all times but especially for the first 50-100 cc. to determine whether or not the patient is going to have a reaction. If the patient should show or express the least symptom of discomfort the transfusion should be stopped immediately. Here again is another instance where one should listen to the patient in order to make a diagnosis. It is important to stop the transfusion as soon as a reaction is suspected, since the prognosis is directly related to the amount of incompatible blood received.

Case Report

H. K., a 36 year old housewife, was admitted to the hospital because of vaginal bleeding of one months duration. She had been pregnant seven times and had six living children. Physical examination was not remarkable. Red count was 2.57 million with 46% hemoglobin.

On the following day a blood transfusion was started. After receiving 100 cc. of blood she complained of severe back pain. Demerol stopped this pain. The house officer thought the patient showed no signs of transfusion reaction, and continued the transfusion. He saw her again after she had received 400 cc. of blood, at which time she was chilling. The blood was discontinued, and the patient given Pyribenzamine. On the following day the patient was quite jaundiced, her bilirubin being 3 mgm. per cent, and her red count was 1.64 million. Her urinary output decreased to less than 100 cc. per day. Her NPN two days after the reaction was 54 mgm. percent and rose to 109 mgm. percent in six days. Despite careful regulation of fluid and electrolyte balance, the patient developed uncontrollable pulmonary edema and died nine days after the reaction.

This patient was typed as A, Rh positive and was given Rh positive blood. A Coombs cross-match performed after the reaction showed the donor blood and the patient's blood to be compatible. When this reaction was investigated in another laboratory, the patient was found to be Rh negative. A Coombs cross-match using a different brand of Coombs serum also demonstrated the presence of Rh antibodies. With this knowledge the patient was then questioned about the child she had lost. It was learned that the baby was quite jaundiced at birth, and had died. It was assumed from her story that she had had an erythroblastotic baby. The cause of the reaction then resolved itself to one of simple Rh incompatibility.

This case illustrates several of the points that have been mentioned above. The first of these is the problem of caution in transfusing women who have had many pregnancies. In the course of this patient's seven pregnancies she had ample opportunity to become sensitized to any blood group which her baby had, and which she did not possess. This brings up the importance of performing a Coombs cross-match test in this type of patient. This brings up the second point, and that is the question of potency of the Coombs serum. One laboratory found this blood to be compatible on a Coombs cross-match, while another using a different brand of Coombs serum found the blood to be incompatible. The third point illustrated involves the problem of the amount of incompatible blood given. This patient was definitely having a reaction by the time she had received 100 cc. of the blood. Had the transfusion been discontinued at this time the outcome would more than likely have been quite different. However, the seriousness of the situation was overlooked, and 300

more cc. of incompatible blood were allowed to enter her circulation.

Discussion

After considering these various reactions individually, it would be well to reanalyze the whole problem of blood transfusions with the idea that certain rules can be found to use as guide-posts to reduce the number of reactions. One must realize that this problem is shared jointly by everyone connected with the transfusion. It involves the donor and his ability to give a careful medical history of himself in order to rule out jaundice, allergy, malaria, syphilis, and other diseases which may be transmitted by blood. It involves the person who draws the blood in that his technique should be flawless, so that he avoids contaminating the blood during this procedure. It involves the technicians in their laboratories and their ability to avoid mixing or losing pilot tubes, their technique for proper typing and cross-matching, and their avoidance of contaminating the donor bottle. It involves the physician who orders the blood and his ability to determine whether or not there is a definite need for the transfusion. It involves the person starting the transfusion, in that he check for hemolysis, that his technique is sterile, and that he watch the patient closely for any signs of reaction throughout the entire transfusion. Lastly, it involves the patients and their ability to give a history of any previous transfusions, pregnancies, or transfusion reactions, and also their ability to tell the medical personnel whether or not they are experiencing any unpleasant symptoms during the course of the transfusion.

With all this in mind the following suggestions are submitted in order that the incidence of transfusion reactions and deaths may be reduced:

1. In interviewing prospective donors one must take particular pains to rule out the possibility of the transmission of any disease. If there is even the least question about certain diseases, notably viral hepatitis, the donor should be rejected.

2. The personnel collecting the blood should be rigorously supervised in technique. They should be given no other laboratory or nursing responsibilities which would tend to interfere with their technique.

3. The banks collecting, processing, and storing blood should be required to meet a minimum set of standards prescribed by a reputable agency, such as the National Institutes of Health. This would assure the physicians that no matter from what source they derived the blood for their patients, it was collected in a uniform manner and processed and stored under the same circumstances as any other blood.

4. The hospital laboratories and the hospital technicians who cross-match the blood should be extremely careful so as to avoid contamination of the blood or mislabeling the bottles after they are cross-matched. Actually, all cross-matches should be checked by a physician.

5. Just before the blood transfusion is started both doctors and nurses should check the bottle to make sure that the proper person is receiving the correct type blood, and see that there is no hemolysis present in the bottle.

6. The doctors and nurses responsible for the patient should check him frequently during the transfusion to be sure that the blood is not being given too fast, and should discontinue the transfusion at the first sign or symptom of trouble.

7. If there is any question at all regarding the sterility of the blood or its expiration date, the blood should not be used.

8. Any person who has had a previous blood transfusion, or any female who has been pregnant should have a Coombs cross-match done on any blood being prepared for transfusion into them.

9. Doctors should take personal responsibility to see that all transfusion reactions are reported to the laboratory and also coded on the patient's chart. This will enable first, more complete investigation of these reactions, and second, will aid in accumulating very vital statistics.

10. Every transfusion reaction should be thoroughly and systematically investigated by the appropriate laboratory. This investigation should be set up to determine first, what type of reaction occurred, and second, what caused the reaction. The donor bottle, pilot tube, and patient should all be retyped and cross-matched. An indirect Coombs test should be performed. The patient's plasma should be examined for evidence of hemolysis. The donor blood should be examined bacteriologically by direct smear, and by culture if a contamination reaction is suspected.

Summary

The use of blood is increasing yearly both on a local and a national scale. In

1949 the American Red Cross alone processed 3,000,000 units and in 1953 processed about 5,000,000 pints. In Louisville, in 1946, four of the larger hospitals gave 7,272 transfusions, while in 1952, 17,299 transfusions were given, representing an increase of 239% in six years.

It has been estimated that there is one death for every 1,000 to 3,000 transfusions given, or a higher mortality rate than that associated with an appendectomy or with an ether anesthesia.

The four major types of transfusion reactions are discussed and illustrative fatal cases reported. These reactions include transmission of disease, bacterial contamination, circulatory overloading, and hemolytic reactions caused by incompatibility between donor and recipient blood.

A set of precautionary measures to be used in reducing the number of transfusion reactions and deaths is submitted.

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Office Gynecology: Diagnosis and Treatment

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The purpose of this paper is to discuss briefly the more common gynecological disorders that can be treated in the office, and to emphasize that most of the common gynecological disorders seen in office practice require only a minimum of special knowledge or special materials. Indeed, a physician can practice very adequate office gynecology with only the aid of a speculum, an electric cautery and a cervical biopsy forcep.

Menstrual Disorders in The Absence of Pelvic Disease

With the exception of hypermenorrhea, the menstrual disorders discussed below are primarily the result of the failure of ovulation. Since no drug has been found that will produce ovulation in the human female, substitutional cyclic hormone therapy must be resorted to in most of the cases treated. Women are often seen who have cyclic menses, but who bleed very profusely the first two or three days of flow, often with passage of large clots. These patients are treated with thyroid, grains one to one and one-half daily. In about one-half of the cases, this will control their hypermenorrhea. Those patients not helped with thyroid alone, are given in addition ten mgm. methyl testosterone tablets three times daily for seven days, beginning on the eighth day of the menstrual cycle. As it is known, the first day of flow is the first day of the cycle.

Another type of functional bleeding is one in which there is no cyclic bleeding at all, the patient bleeding daily or almost daily for two to six weeks. In treating these cases, the greatest success has been had using progesterone, fifty mgm. daily for two days, intramuscularly, and thyroid, grains one to one and one-half daily. Thyroid should be used over a period of two to three

months. Then, finally, those patients are seen occasionally who have had cyclic periods of normal flow, but who now present themselves with histories of very scant menstrual flow, still cyclic, or complete cessation of menses, i.e. secondary amenorrhea. These patients certainly have ceased to ovulate. Following is the regime which has been found to be most successful: stilbestrol, one mgm. daily for seven days; stilbestrol two mgm. daily for seven days; stilbestrol, three mgm. daily for seven days, followed by progesterone, twenty-five to fifty mgm. daily for two days. Within a week of the last injection of progesterone, most of these patients will have a good menstrual flow lasting three to five days. After cessation of flow, the above is repeated through two more cycles. Thereafter, the majority of these patients will revert to normal cyclic ovulatory menses. As with other types of menstrual irregularities, thyroid, grains one to one and one-half daily should be used for long periods of time. Finally, it should be emphasized that any woman forty years of age or older who is bleeding irregularly must be curetted to rule in or out adenocarcinoma of the endometrium.

Vaginal Discharge

Discharge arises from: (1) the vagina, itself, secondary to vaginal infection, and, (2) from the cervix. There are three common infections of the vagina. First is the gonorrheal vulvovaginitis of children with its thick, creamy yellow discharge and inflamed vulva and vaginal mucous membrane. The etiological agent is the gonococcus and diagnosis is made by stained smear or culture. Treatment consists of penicillin, sulfonamide and sometimes stilbestrol. The latter is of value in resistant cases by thickening the vaginal mucous membrane and lowering the pH of the vagina. Dosage is 0.50 to 1.0 mgm. daily, orally. Breast engorgement will occur which is unimportant and will disappear after the drug is discontinued. Vaginal suppositories of stilbestrol are no more effective than oral administration.

The second of the vaginal infections is Trichomonas vaginalis vaginitis. This produces an intense reddening of the vaginal mucosa, irritation and pruritis in over one-half of the cases and a characteristic thin frothy yellow-white discharge. The etiological agent is the trichomona, a motile, flagellated protozoa and diagnosis is confirmed by examining an unstained hanging drop suspension of the vaginal discharge microscopically in which the trichomona are easily seen. The underlying principle of treatment consists in creating and maintaining a pH markedly on the acid side as the trichomona cannot survive in an acid medium. Specifically, these patients are treated in the office with hexylresorcinol (S.T.37) in the vagina, followed with insufflations of powdered Floraquin and carried on treatment at home with Floraquin suppositories, one in the morning and one at bedtime with a daily vinegar douche. The suppositories are used also during menstrual flow and the whole regime is used throughout three menstrual cycles.

The third common vaginal infection is Monilia or yeast vaginitis. This produces an intense reddening of the vaginal mucous membrane, irritation, pruritis and a very characteristic thick, cheesy discharge that adheres to the vaginal walls. Diagnosis is confirmed by microscopic identification of yeast buds, either in the unstained hanging drop slide or stained smear. Yeast vaginitis is seen very commonly in pregnancy and if not treated, produces Thrush in the new-born. Fortunately, this fungus is destroyed easily by gentian violet, one to two percent either in water or glycerin and this, along with maintaining a very low pH of the vagina with vinegar douches and Floraquin suppositories, remains the treatment of choice. Gentian violet is applied locally in the office on one or two occasions and gentian violet suppositories (trade-name Gentia-jel) are prescribed to be inserted once daily at home, along with vinegar douches. The douches should not be used in the last trimester of pregnancy, but the gentian violet suppositories may be used without danger until the patient goes into labor.

Although the above conditions are commonly seen, by far the most common type of vaginal discharge arises from cervical disease, especially chronic cervicitis. This produces the so-called non-specific mucopurulent discharge. The patient has almost always had one or more children and examination of the cervix reveals this organ to be lacerated, eroded, frequently hypertrophied and often the cervical lips are everted. The underlying etiology is childbirth, the cervix being lacerated as the head of the fetus passes through with resulting secondary infection of the laceration. Often these cervices have one or

more blue-domed cysts present which are retention cysts of the endocervical mucous glands, secondary to chronic infection. They are called Nabothian cysts and are easily destroyed by puncture with the cautery tip. The treatment of chronic cervicitis and endocervicitis where malignancy is not present is by use of the nasal tip cautery. The application of antiseptics, astringents and other solutions has no place in the treatment of this disease. Cauterization is safe, rapid, painless and can usually be accomplished with one office visit. After cautery, healing will be facilitated by maintaining a low pH of the vagina so vaginal creams, jellies and/or vinegar douches are indicated. A follow-up visit to the office four to six weeks after cauterization is mandatory for two reasons. One: to check on healing, and, two: to be sure there is no stricture of the cervical canal, secondary to cauterization. If some stricture of the canal has occurred, and this is infrequent, gentle dilatation of the canal in the office without anesthesia will easily overcome the stricture.

Lastly, rather frequently, those patients are seen who give a history of slight bloody vaginal discharge between periods and often following intercourse. In these cases, speculum examination will often reveal a polyp at the external os. These polyps arise from the cervical canal and are almost never malignant. They are easily removed in the office by grasping the stalk of the polyp within the cervical canal and twisting until the polyp and stalk come away.

Carcinoma of The Cervix in Relation to Office Practice

It is well known that the most important aspect of carcinoma anywhere in the body is early diagnosis. Without question, the great majority of cervical carcinoma can be diagnosed in the office. When a patient presents herself with a history of: (1) post-menopausal bleeding, (2) intermenstrual bleeding, especially following intercourse, or (3) a foul watery discharge, it must be assumed that patient has carcinoma until proven otherwise. Fortunately, a simple speculum examination along with cervical biopsy almost always establishes or refutes the diagnosis of cervical carcinoma. The question arises, when should a cervix be biopsied? Ideally, all diseased cervices should be biopsied, but this is not always practical. Certainly, every cervix that bleeds easily or has a discrete ulcerative lesion or cauliflower growth must be biopsied. Biopsy in the office is adequate for diagnosis, easy, safe and relatively painless. Where no discrete lesion exists, biopsy should be taken at the junction of the squamous and columnar epithelium just inside the external os, for it is here that most carcinoma arise.

Premenstrual Tension and Dysmenorrhea

Another condition commonly encountered in the office is premenstrual tension and dysmenorrhea. Premenstrual tension is the name given to that symptom complex which appears several days prior to menstruation and is characterized by tension, irritability, depression, headache, edema and abdominal bloating. It is often associated with dysmenorrhea and there is considerable overlapping of the two conditions. This is a very real problem, both to the housewife and to the woman who works, and is responsible for considerable absenteeism in industry. The cause of premenstrual tension is unknown. A tremendous amount of investigative work has been done which indicates that hormonal imbalance, especially the anti-diuretic hormone of the pituitary, and hypoglycemia may be important causative factors. The important thing is that in recent years, clinical use of antihistamines, combined with simple analgesics and sedatives are very effective. A preparation called Neo-Bromth, two tablets twice a day, beginning seven days prior to menses has been used successfully. This is a harmless drug containing no narcotic and relieves these distressing symptoms in seventy-five to eighty percent of cases.

Sterility

In the management of the potentially sterile couple, there are three basic factors to be determined: One: the fertility or infertility of the husband as determined by semen examination. In those communities where conditions exist for complete semen analysis, including sperm count, motility, abnormal forms, etc., this should always be done. Where these facilities are not available, a simple Huener test is very informative. This is a procedure in which the wife is examined by the physician very shortly after intercourse and a droplet of the semen is taken from the vagina and examined microscopically for observation of sperm in gross numbers and for motility.

The second factor to be determined in

sterility study is whether or not the woman ovulates. This can most often be determined by basal temperature graph. In those cases where the woman in question has irregular periods, or for any other reason a question of ovulation arises, an endometrial biopsy two or three days prior to the next expected menstrual period can be performed in the office.

The third factor to be determined concerns the patency of the fallopian tubes. This requires special knowledge and materials, but is an office procedure. This is determined by either a Rubin test or by hysterosalpingogram.

In addition to determining the above factors, any pelvic disease found should, of course, be eradicated. Not infrequently, chronic cervicitis with its mucopurulent discharge plays a significant part in preventing pregnancy and should, when present, be corrected by cauterization.

Retrodisplacement of the uterus seems to be a factor in sterility only very infrequently. Nevertheless, when retrodisplacement is present, it should be corrected by pessary insertion.

Pessaries

The use of pessaries continues to play an important role in the management of gynecological disorders, and with the very infrequent exception, is an office procedure. They are useful in the following disorders: (1) uterine prolapse; (2) as a diagnostic aid in determining the relationship of retrodisplacement of the uterus and low back pain; (3) correction of retrodisplacement of the uterus associated with an enlarged, boggy uterus most frequently seen in the postpartum period; (4) in the infrequent case where retrodisplacement is a factor in sterility.

The large majority of patients who suffer from uterine prolapse can now be successfully managed with surgery. The pessary is important in holding the uterus in place until proper preparation of the patient can be accomplished prior to surgery, and in the occasional patient who is too poor a surgical risk for operative correction of her prolapse.

In those patients who present themselves with low back pain in association with retrodisplacement of the uterus, pessary insertion is the best way to determine whether any relationship exists and should always be done before any surgical procedure to correct retrodisplacement of the uterus is undertaken. Actually, very few cases of low back pain are due to a retrodisplaced uterus and suspension operations, so popular and so often abused in the past, are only infrequently indicated. Pessaries may be worn by a patient for long periods of time, but should be removed, cleaned and re-inserted at four to six week intervals.

Summary and Conclusion

An attempt has been made in this paper to discuss briefly the more common gynecological disorders that can be adequately and properly managed in the office. It should be emphasized again that most of the conditions described in this paper require little special knowledge and only a minimum of special equipment.

The problem of pelvic carcinoma and especially carcinoma of the cervix is always present and a special plea is made for speculum examination of every patient with more frequent cervical biopsies and eradication of cervical infection by cauterization.

CORRECTION

The Journal regrets that the following errors were made in the publication of "The Diagnosis of Bacterial Endocarditis," by Buford Hall, M.D., Lexington, in the July issue:

Page 502, column 1, line 9, should read "as was true in 26 of our cases."

Page 503, column 1, sentence 1, should read "Four patients revealed positive results on the second, second, third, and fifth cultures respectively."

Page 503, column 1, line 4, should read "The remaining 38 cases had positive cultures on the initial venepunctures."

Page 503, column 2, line 5, should read "in a patient over 10 years of age strongly favor bacterial endocarditis, while subcutaneous nodules, erythema marginata, frank arthritis and chorea point to rheumatic fever."

Physical Examination of the Injured*

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New York, New York

General Considerations

Because its findings determine diagnosis, prognosis, and treatment, physical examination is the first and perhaps the most important procedure in the management of any injury. Comprehensively reviewed, the examination is essentially a process of noting the features of the injury and the patient's reaction to it. To do this adequately, the examiner must obtain the fullest information possible on the following points:

1. The character and extent of obvious injury
2. The possibility of any coexistent concealed injuries
3. The presence of any disability which may be affected by the injury
4. The general condition of the injured subject.

Theoretically, the examination of injury cases should be completed with the same careful regard for detail exercised in the examination of those with less urgent complaints. Practically, such detailed examination is seldom possible for the character of the injury, condition of the patient, and inadequacy of facilities place restrictions on the examiner. Disregarding such restriction in the over-zealous attempt to perform complete physical examination upon severe injury cases is likely to result in additional harm and gain slight additional information. Thus the physical examination of injured subjects must in many instances be of necessity limited or considerably modified. But let it be emphatically pointed out that this in no way excuses the examiner from making the fullest examination allowed by the limitations of any individual case.

Certain general precepts obtain in the examination of all instances of trauma. Because they are likely to be unfamiliar to the novice and frequently neglected by the experienced examiner they are emphasized as follows:

1. An examination must be made however and whenever possible with the injured in a conscious state. The state of consciousness determines to a very large extent the amount of accurate information the injured subject can give concerning the circumstances of his injury and his subjective symptoms. It must be remembered that the state of consciousness in traumatic cases may frequently change in very short periods. The examiner must therefore take advantage of any conscious interval, wherever or however it occurs, to gain as much information as possible. Regardless of how many examinations have been carried out with the injured subject in a comatose or wholly unconscious condition, additional examination must be made as soon as possible upon return to full or approximately full consciousness. The importance of this rule in its relation to the discovery of concealed internal or spinal injuries is so apparent as to need little elaboration.

2. Examinations must be repeated. The necessity of frequently repeated examinations in injury cases must never be underestimated. It is true that the initial examination is the basis of comparison for all subsequent examinations and the main factor in the index of the progress of the patient. During this initial examination the initial estimate of the injury and the general condition of the patient is made, and the course of management tentatively outlined. But, it frequently happens, the appearance and responses of the severely injured are, on initial examination, deceptively good. If overmuch is taken for granted at this time, the rapid onset of dangerous reverses may be discovered too late. Hence the repetition of examination at frequent intervals is emphatically indicated. It is not necessary that the examiner perform the complete procedure of examination each time the patient is observed, but certainly those features of which he may be in doubt.

3. During initial and subsequent examination, the injured should be disturbed as little as possible. It may be axiomatically stated that the same careful handling be exercised in the examination of severely injured cases that is observed during definitive treatment in the operating room. Indifferent insistence upon active or passive motion of body parts in critically injured subjects accentuates trauma. It also

*Furnished by and published with the permission of the Committee on Trauma of the American College of Surgeons.

stresses the following maxim, "Absolutely no attempt should be made to move the patient bodily until examination reveals how movement and transportation can best be accomplished." Abuse of this consideration can result in deeper shock, further hemorrhage, and accentuation of spinal or other injuries.

4. Following the initial or any subsequent examination the significant features must be immediately recorded. It is scarcely necessary to point out that failure to properly record all significant findings and the time at which they are noted, is likely to result in detriment to the patient, embarrassment for the examiner who has neglected to do so, undue difficulty for any subsequent examiner, and frequent medicolegal complications.

5. The employment of a systematic routine in performing examination is advisable. This above all saves time and tends to develop close habitual observation on the part of the examiner. It is often expedient to render treatment of some form before completing the examination; indeed, it is frequently absolutely necessary to do so before the examination can progress without unduly endangering the patient. If the examination is systematic, any immediate and necessary treatment is also more likely to be well ordered and properly applied.

Specific Features

Bearing the above general considerations in mind, it is appropriate to emphasize certain more specific features particularly concerned in the examination of traumatic cases. For comprehensive discussion these features may be categorically separated into these parts.

I. Features pertaining to the history of the injury.

Either from the injured subject himself or, when that is impossible, from any and every other reliable source, the examiner must seek the fullest information on the following points:

1. Time and circumstances of occurrence of the injury.

2. State of consciousness of the injured at the time of and following injury.

3. Any disease or disability existing prior to or at the time of injury.

4. Any treatment previously rendered to the injured.

The time of and the circumstances under which the injury was inflicted in the main determine the likelihood of wound infection and the probability of the deterioration of the patient's general condition from shock or hemorrhage. The longer the time elapsing from the incidence of the trauma, the greater the prospect of the presence of such complicating factors. The circumstances of the injury, particularly the locality where and the agent by which the trauma was inflicted are also indicative. These factors also determine the possibility and type of infection and certain considerations of definitive treatment such as extent of any debridement, feasibility of primary treatment, and the administration of antitoxins or antibiotics.

Information on the state of consciousness of the subject at the time of and following injury is always essential. A period of unconsciousness produced by or following injury always suggests the possibility of intracranial trauma. But it must also be remembered that unconsciousness may have occurred before or at time of the injury from other than traumatic causes and may indeed have been responsible for the injury itself. In this event the examiner must be particularly careful to search for any nontraumatic cause of the unconsciousness.

Pre-existent disease or disability may not only account for the unconscious or comatose state of the injured but for other unexpected findings as well. The presence of such may greatly influence diagnosis, prognosis, and treatment, and the possibility of their presence must constantly be kept in mind by the examiner. Alcoholism, diabetes, epilepsy, and cardiac disease, among many others, are familiar examples of conditions which may not only be directly responsible for the injury but which may also be greatly affected by it.

Finally, any treatment previously rendered to the injured must be ascertained by the examiner. Too often in the confusion following instances of severe injuries, particularly when multiple casualties have occurred, some medication such as morphine or alcohol has been administered, a fact which may not be recorded and forgotten by the patient unless specifically queried. The examiner must never ignore this feature, for ignorance of it will confound his examination with false findings and imperil subsequent rational treatment.

II. Features pertaining to the general condition of the injured.

Grave and even fatal errors in the management of traumatic cases occur because the examiner becomes so preoccupied with the injury itself that he neglects the general condition of the patient who has sustained it. Such will not occur if it is thoroughly impressed in the examiner's mind that preservation of the life of the injured when endangered is his primary objective and, only when this is assured, can any definite measures be taken concerning the specific injury. The rule, therefore, may be categorically stated that, in the examination of any traumatic case, the examiner must first determine that the life of the injured is not endangered before any detailed examination of the specific injury can be undertaken. In short, an evaluation of the patient's general condition should always precede that of his specific injury. A reasonable estimate of the general condition of the injured can be gained by close attention to the following features.

1. Age, development, and nutrition. The same injury is not the same in all individuals who sustain it. This is true because the body reaction to trauma varies with age, development, nutrition, and state of health. In the young and robust such injury as an open fracture of the femur may be surprisingly well tolerated because the compensatory reaction capacity is good. In the aged, debilitated, or infirm, in whom this capacity is reduced, such trauma makes the patient's general condition a matter of general concern. The general physiological disturbances incident to severe trauma are most pronounced at the extreme of age—in early youth when the protective responses of the body as a whole are undeveloped, and in advanced aged where they are reduced by debilitation and senility. The complicating factors such as shock are far more prone to occur.

2. State of consciousness. It has already been pointed out that the state of consciousness of the injured may indicate a disease or disability present before injury and possibly responsible for it or may be the result of intracranial trauma occurring at the time of injury. But when these factors are excluded, the state of consciousness of the injured may be an index of the patient's general condition as influenced by shock, concealed hemorrhage, or unrecognized overdosage of narcotics.

3. Respiratory and circulatory status. Any traumatic process of sufficient degree to offset the general condition of the injured will be reflected by detectable signs in the respiration and circulation. Very frequently in wholly unconscious patients respiratory and circulatory changes may be the only signs of dangerous deterioration in his general condition. Even without more specific and time consuming laboratory procedures which may be indicated, an immediate and reasonably accurate evaluation of the patient's general condition can be deduced by observation of the rate, force, and rhythm of the pulse, color, texture, and moisture of the skin and mucous membranes, and the body temperature, particularly in the region of the extremities.

If any marked embarrassment is noted in either respiration or circulation, it is a wise precaution to begin supportive therapy at once, even at the expense of delaying further examination until proper response is shown. Only when the examiner is satisfied that the patient's general condition is satisfactory to allow it may he proceed with investigation of the features of the specific injury.

III. Features pertaining to the character and extent of the individual or specific injury.

Often the nature of the injury is such and the marks of external violence and deformity so obvious in a given body part as to direct the attention of the examiner immediately to that part. Nevertheless, he should usually proceed to the examination in a sequential order and examine the area of the obvious injury in its proper turn. Exceptions to the general rule are instances in which the obvious injuries are such as to require urgent attention and treatment before the examination can be completed; for example, obvious fractures and actively hemorrhaging wounds. In this event he should complete whatever treatment is necessary as rapidly as possible and continue the examination on an orderly basis.

It is usual to begin the examination with the head and progress downward in order, the neck, thorax, abdomen, perineogenital area, and extremities. The ordinary position of the injured subject when under examination is supine, making the anterior body surfaces accessible but concealing the posterior. Neglecting to turn the patient to investigate the posterior aspects as well may result in failure to recognize obvious and severe trauma concealed by the usual supine position. This is par-

ticularly prone to occur in the unconscious or comatose. The examiner, therefore, must take care to examine body parts from all aspects. The experienced examiner of traumatic cases knows that there are certain features common to all injuries regardless of the locality in the body where the injury exists, and that these features when present may be detected by the most commonplace clinical methods—inspection, palpation, percussion and auscultation. All of these features indicating the location, character and extent of the injury may not be present in any one injury but, invariably, one or more are and, when present, should warn the examiner to search carefully for the others. However, when one or a number of these universal features is noted in a given body part, their presence should stimulate the examiner to investigate fully the anatomy and function of that part for additional information.

These common pathological features commonly present in all injured body parts are (1) external marks of violence, (2) deformity, (3) pain, (4) tenderness, (5) rigidity and voluntary spasm, (6) loss of function in the part. External marks of violence are apparent external lesions of body tissue, obviously produced by contact with traumatic agents or through traumatic forces. These are usually in the nature of abrasions, avulsions, contusions, lacerations, incisions, perforating wounds, and abnormal masses in the affected parts. They are in themselves injuries and indicate in the affected part the manner in which the injury was inflicted. When present they are of significance for they serve to draw the attention of the examiner at once to the individual part, but it must never be forgotten that severe and even fatal injuries in certain body parts, for example, head, chest and abdomen, may occur without any detectable external marks of violence whatever. Thus the absence of external marks of violence in no way excludes the possibility of injury or the necessity of examination of the apparently normal body region. Besides the ordinary marks of external violence above noted, the injured part may show deformity consisting of abnormal positional relationship of the injured part to adjoining parts or to the body as whole. Such is particularly characteristic of injury to underlying bony, ligamentous and joint structure. Abnormal positional relationship of the injured body part may also be maintained and accentuated by involuntary muscle spasm and voluntary splinting. In the conscious patient there is a natural tendency to immobilize the injured part by voluntary muscular action in a position of less discomfort. There is, however, an element of true involuntary muscular spasm, reflex in origin, frequently detected even in comatose or unconscious subjects. Pain and tenderness are in general most valuable signs in localizing the injured part and in estimating its severity. They are, however, in the nature of subjective sensations and, therefore, require consciousness on the part of the injured. In the unconscious or deeply comatose they are difficult or impossible to elicit, and the examiner is therefore considerably handicapped. It is rarely that any injury of any magnitude can exist in a conscious individual without producing at least some degree of pain and tenderness in the part affected. The examiner should bear in mind that many injuries of a relatively mild character can produce pain and tenderness far out of proportion to their severity and conduct his examination with appropriate gentleness. Conversely, it is also true that injuries of an extremely severe nature in which vital processes are dangerously impaired may occur with little pain to indicate their gravity. He must therefore be somewhat circumspect in the evaluation of the presence of pain and tenderness alone as indices of the extant injury.

Loss of function is an extremely significant finding in determining the location and extent of the injury in any affected part and therefore must always be sought for. Moreover, the examiner must be constantly aware of the fact that loss of function in a given part may be produced by ce-existent injury to regions remote from the part itself, as, for example, in damage to the central nervous system. While in many instances of severe injury the nature of the functional impairment may be apparent from observation alone, it is frequently not so and must be specifically tested for by the examiner. Few errors will occur if he will test the sensory and motor functions of the part and its response to reflex stimulation.

Order of Procedure for Physical Examination of the Injured

The procedure suggested below is one which has proved entirely satisfactory in the management of a large number of traumatic cases and is advanced here as a method by which most errors can be a-

voided. It will be noted that the method of procedure subsequently noted is by no means complete and is not advanced as such; it is designed only to help the examiner discover and evaluate immediately the important features of the case in a minimum of time without causing undue harm to the injured.

1. Immediate control of any obvious accessible hemorrhage by pressure or tourniquet; immediate splinting of obvious deformity of the extremities requiring immobilization. Immediate treatment of obvious shock or depleted circulation by administration of supportive measures including intravenous fluid. In other words, first attention to obvious conditions which are endangering the patient's life.

2. Removal of all clothing by cutting it away with minimal disturbance of body parts, and the substitution of blankets for the excised garments. In brief, make all body parts readily accessible for examination and treatment.

3. Determination by direct questioning of the relevant state of consciousness of the injured and thereafter the extent of his co-operability during the examination and the reliability of his statements.

4. Rapid notation of the history of the injury, preferably from the patient himself, or in the event of his inability to cooperate, from the best immediately available source; time and circumstances of occurrence, state of consciousness, at and following injury, precedent disease or disability and previous treatment rendered are all minimal essential points in the history. But, if information cannot be obtained on all, the examiner must make every effort to establish the two of the most urgent import—the time of injury and whether or not any narcotic has been previously administered.

5. Examination of the respiration by observation of the rate, depth and rhythm. All things being equal, changes in the respiration and circulation generally parallel and reflect each other; but, in every instance, the examiner must be sure that the patient's breathing is not obstructed by recession of the tongue or the aspiration of blood or vomitus, and that the lungs are not deflated by pneumothorax, since these conditions require immediate relief. He must therefore absolutely include an examination of the patient's open mouth and percussion and auscultation of the patient's chest.

6. The examination of the circulatory state of the patient by observation of the rate, force and rhythm of the pulse, the body temperature particularly in the region of the extremities, the color, texture and moisture of the skin and mucous membranes, and the blood pressure. Determination of blood pressure alone as the sole index of the patient's circulatory state is never sufficient for the patient's effective circulating blood volume may be dangerously depleted by latent shock or hemorrhage without significant change in the blood pressure. The other indicative signs of diminished blood volume must be investigated as well as the blood pressure in every instance.

7. Estimation of the general condition of the patient. By the time this stage of the examination has been reached, the examiner will have acquired sufficient information for reasonably accurate conclusions as to the general condition of the patient. Often in severe injuries the grave nature of the patient's general condition is obvious and proper supportive measures have been instituted long before this stage of the examination has been reached. If, however, due to equivocal physical findings, the examiner has delayed estimation of the general state of the injured, he must make that evaluation now before proceeding to a more detailed examination of the individual injury to specific body parts. When in doubt as to an estimate of the patient's general condition from the signs presented, the examiner should take the precaution of beginning supportive treatment without awaiting further confirmation.

8. Examination of individual body parts for specific injury. With or without supportive measures in progress, the individual body parts are generally investigated in turn, proceeding downward from the head and terminating with the lower extremities. The features common to all types of injuries, namely, external marks

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CASE DISCUSSIONS

Due to the additional amount of Annual Meeting material which is being published this month, a regular feature of the Journal of the KSMA, "Case Discussions," will not be included in the August Scientific Section. Publication of this feature will be resumed in the September issue.

SPECIAL ARTICLES

HOW CAN THE COUNTY MEDICAL SOCIETY BEST SERVE THE PUBLIC?*

WALTER B. MARTIN, M.D.

Norfolk, Virginia

President, American Medical Association

I am very happy to be here today but I feel I am talking to a group who knows as much or more than I do about this subject. You have already demonstrated this by giving the country in 1953 the general practitioner of the year, Joseph I. Greenwell, M.D., of New Haven, who exemplifies so well the relationship that should exist between the practitioner of medicine and his community. He has held high the standard of good medicine and yet found time to serve his community in many capacities. You have shown the interest of your state in medicine by the strong leadership you have furnished the American Medical Association in the persons of such outstanding individuals as Irvin Abel, M.D., Fred Rankin, M.D., and Elmer Henderson, M.D., and the able men you have sent each year to our House of Delegates. The local societies are the combat troops of medicine. No matter how carefully we plan at the national level, how diligently we develop facts and formulate policies, our efforts are in vain unless these shock troops of medicine take the field.

The county societies vary a great deal in size, composition and scope of their organization and activities. It is interesting to note that, of the 1932 county medical societies, 1705 have membership of less than 100. One hundred and fourteen have a membership of 100 to 200 and only 113 of all the county societies in the United States have a membership of over 200. It is obvious that no set pattern can be formulated as to how all societies can best support and aid the public. These figures illustrate, however, the tremendous importance of the small society not only because they are distributed widely throughout every state but also because their members as a whole are more closely in touch with the people in their community.

Each county society should understand the purpose and the rational of AMA policies. This does not mean that they should follow these policies in all detail, but it does mean that they should understand them and, if they find themselves in disagreement, that they should pursue an orderly course in making the nature of their disagreement known to their state society and to the AMA delegate. The policies of the American Medical Association are not formulated by small groups sitting in isolation. The vital, declared policies of the American Medical Association are set by its House of Delegates. Any of the AMA policies can be challenged in the House of Delegates by the delegates from your state or any other state. It is necessary, however, that once policies have been established through action of the House of Delegates, that the members of each county society make themselves familiar with these policies and the underlying facts and reasons behind their adoption.

Wars are not fought nor battles won with field troops alone. Back of the forces in the field are many staff activities, collecting information as to the enemy's capabilities and intentions, supplying needed material, formulating strategy with the details of tactics left to the field command. I could carry this analogy further, but it is obvious that it is the duty of the national organization to accumulate facts and figures bearing on the quality and quantity of medical care available, driving for constant improvement of this care, and passing on to the local society factual material that will enable them to implement the proper policies of the American Medical Association.

Your national association through its councils and bureaus, its board of trustees

*Read before the Fourth Annual County Society Officers' Conference, April 15, 1954, Lexington.

and general officers constitute the staff of the field troops. Unlike a military force, the AMA has no authority over the state association or the component county societies. We can inform you and advise you but cannot direct you. Nevertheless, our strength is in the county societies.

There are many problems that face medicine today. The changing pattern of medicine, the expansion of hospitals and other medical facilities, the growth of specialization and the increase in the overall cost of the health services for the American people, have served to multiply and make more complicated these problems. Medicine has become somewhat less personal. The people are disturbed. On the one hand, they have a nostalgic desire for the comfort of a personal advisor. On the other, they have an uneasy feeling that they may not be benefited by the latest miracle of medicine so glibly described in the press and magazines. They are pinched by the rising cost of all commodities. When the inevitable strikes, they are unduly impressed by this particular cost factor in their total financial woe. They cheerfully purchase a television or a new car on time, but hesitate to buy protection against the cost of illness in the same manner. The reason is obvious. They want a television and they don't want an illness. They blindly hope that they won't have to pay for one.

The county society through its members can take an active part in all agencies concerned with community welfare, particularly those that have a connection with health. It can promote the formation of health councils and interest itself in the public health phase of medicine. It can work with the local health department in improving and extending public health services in each community. It can stimulate its members to activities in civic clubs, religious organizations and in the educational field. Individual members can support the Community Fund or Chest by contributions of time and money. Through all of these activities, the county society can make itself felt in every worthwhile phase of community life.

The county society and its members should also be aware of the needs of their community from the standpoint of hospitals and other medical facilities. It should try to improve the qualities of existing facilities and to extend them when the need exists. It should be the objective of the county societies to improve their communities in every way that will promote the total community welfare and make it a more desirable place in which to live.

The county society should constantly endeavor to improve the quality of medical care in their community and to improve the professional status of its members. Through scientific meetings, journal clubs, hospital staff meetings and by encouraging qualified younger men to come into an area where they are needed, the general level of medical practice can be consistently improved.

The rapid expansion of voluntary prepayment insurance against the cost of hospital care and the medical and surgical care in the hospital has been one of the striking developments of the last twenty years. At the present time over 90 million people have some type of coverage against hospital costs, 70 million against surgical and 35 million against medical care in hospitals. These figures are still expanding. It is notable that the highest percentage of coverage is in the highly industrialized states and in the great industrial centers. Coverage has lagged in the towns and rural areas. The county society can do a great service by surveying its own area and by working out plans to extend to a greater degree the benefits of the voluntary pre-payment plan in its own community.

Abuses have developed in the field of pre-payment insurance and the county society can promote community welfare by aiding in the correction of these abuses. If voluntary pre-payment fails to accomplish its full purpose, it will be because of such abuses as unnecessary hospitalization, prolongation of hospital stay, and overuse of the special hospital services. The effect of over-use is to increase the total hospital and professional cost to the community. This cost is bound to be reflected in increased insurance rates or depreciation in quality of hospital care. It will eventually be influential as a result of higher premium charges in retarding sales of this type of insurance. Failure of the pre-payment plan to continue to expand, particularly in non-industrial areas not now well covered, will result in increased pressure for further extension of the federal government in the field of medical care.

The AMA has formulated definite policies in the field of medical care of non-service connected veterans and the de-

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Bruce Underwood, 620 S. Third Street, Louisville	1955
Coleman Johnston, 211 W. Second Street, Lexington (Alternate)	1955

COUNCILORS

		Term Expires
First District	J. Vernon Pace, 709-10 Citizens Bank Bldg., Paducah	1956
Second District	Walter L. O'Nan, 700 Elm St., Henderson	1956
Third District	Delmas M. Clardy, Hopkinsville	1956
Fourth District	W. Keith Crume, Bardstown	1956
Fifth District	Richard R. Slucher, Buechel	1954
Sixth District	L. O. Toomey, 544 E. Main St., Bowling Green	1954
Seventh District	Branham B. Baughman, 401 Main St., Frankfort	1955
Eighth District	Edward B. Mersch, 92 Arcadia, Covington	1954
Ninth District	J. M. Stevenson, Brooksville	1955
Tenth District	J. Farra Van Meter, 183 N. Upper St., Lexington	1955
Eleventh District	Hugh Mahaffey, Richmond	1954
Twelfth District	Garnett J. Sweeney, Liberty	1956
Thirteenth District	Charles B. Johnson, Russell	1955
Fourteenth District	John Archer, Prestonsburg	1956
Fifteenth District	Edward Wilson, Pineville	1954

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EDITORIALS

NEW LINKS IN THE CHAIN OF PROGRESS

Vision, honest soul-searching and a bold effort to strengthen possible weaknesses plus intelligent planning have all been combined to make the 1954 annual Scientific Assembly not just another meeting, but truly an outstanding event in Kentucky medicine.

The Committee on Scientific Assembly, of which J. Duffy Hancock, M.D., served this year as chairman, began laying the groundwork for the 1954 meeting soon after the close of the 1953 annual session.

The 1953 assembly, with the exception of the Centennial Meeting, was the best on record from the standpoint of attendance and general interest. This gave the committee a high goal to shoot for.

Typical of the progressive spirit that characterizes the leadership of K.S.M.A., the committee at its first session went to work on plans calculated to provide the maximum practical information which will be profitable to as large a number of K.S.M.A. members as possible.

The committee took another highly important step by providing for more widespread program participation by more members than ever before. This is evidenced by a glance at the 1954 program, which you will find given in detail near the front of this month's Journal. All who have had an opportunity to preview the program as set up have been most enthusiastic about its potential.

A large part of the program's potential, however, is not wrapped up in guest speakers or scientific sessions. The largest potential this or any other association program can have is YOU, the members of the K.S.M.A. Your interest, your cooperation and your attendance will provide the needed stimulant to make the 1954 session the best ever.

One of the distinctive features of the assembly will be the Wednesday afternoon session. At this time eight specialty groups, including the Academy of General Practice, will present scientific programs simultaneously. This innovation is designed to permit the specialty groups to have their highly technical sessions and to encourage participation by a larger number of K.S.M.A. members.

Each of the specialty groups will have an outstanding, nationally known guest speaker at the Wednesday afternoon session. These eight visiting essayists will also speak before the general sessions. In addition, three other nationally recognized men will speak at the general session.

Other highlights of the program include the symposiums on "Physical Examination" and "X-Ray Interpretation" and the "Biopsy Panel." All of these features will most certainly command the attention of all practitioners who wish to attain a higher degree of professional efficiency and stimulate a determination to attend every one of the sessions.

ASPIRATION OF BREAST CYSTS

For the past twenty-five years occasional recommedations have appeared in the literature for the employment of aspiration in the diagnosis of breast tumors. Recently, faced with the necessity of screening an abundance of pathologic breast conditions flushed out by current cancer detection drives, and influenced, no doubt, by present trends of increasing distaste for unnecessary surgery, surgeons are looking favorably upon aspiration as a diagnostic and therapeutic measure in the management of abnormal breast masses. Articles appearing in current surgical literature, advocating the use of aspiration in this way, have laid down certain fundamental principles for its use, as follows:

(1) All masses which, on attempted aspiration prove to be solid, should be excised promptly.

(2) All masses which do not completely disappear with aspiration should be immediately excised.

(3) All cysts containing grossly bloody fluid should be excised for biopsy.

(4) All cysts that refill after one or two aspirations should be excised.

(5) Small cysts less than 1 centimeter in diameter should not be aspirated but should be excised.

(6) Cysts extending beneath the areola should not be aspirated but should be excised.

(7) Fluid obtained by aspiration should be centrifuged and studied histologically. If suspicious cytologic features are present, the cyst should be excised.

(8) All patients should be carefully instructed in breast self-examination and followed closely by a physician. This should be an essential part of therapy.

(9) Aspiration should be done only by one trained in surgery of the breast and aware of its limitations.

The advantages of this method of attack have been stated as follows: First of all, it is claimed that the method, when conducted according to the precautions already stated, and when backed up by surgical excision or biopsy of suspicious lesions, is no less accurate than surgical excision or biopsy employed routinely for all such lesions. It is undoubtedly less expensive, less painful and less inconveniencing to the patient. It is also stated by its advocates that it provides more prompt and complete psychological relief from the fear of cancer than does excision or biopsy. It is argued that the procedure does not, in general, delay the diagnosis of, and the initiation of definitive treatment of, the unsuspected cancerous nodule. which, it is estimated, occurs in most series of cystic disease in the ratio of one or two per hundred cases.

While it cannot be denied that some very definite advantages are presented by this method, nevertheless there are certain pitfalls in the method and certain inappropriate psychological features which should be pointed out. First of all, no one would attempt to claim that the method is superior in accuracy or efficiency to routine excision or surgical biopsy of all such lesions. The claim that it is no less accurate than surgical biopsy does not take into account that the first one or two aspirations should very properly be classed as diagnostic errors if later excision biopsy becomes necessary, whether or not cancer is subsequently found. When this is done, the batting average for the procedure drops to about 87%, as compared with nearly 100% for excision biopsy. One is inclined to doubt the statement that the relief from the fear of cancer is more prompt and more complete than with an excision biopsy which has proved beyond the peradventure of a doubt that cancer is not present in the area excised. Not a few intelligent and well informed patients mistrust the office procedure of aspiration and only feel satisfied when the more traditional method of biopsy and microscopic study of the tissue removed has proved that there is no cancer present. Then too, if, as its proponents state, we must impress upon the patient whose cyst has apparently disappeared with a single aspiration, that she must return for checkups to be sure that the mass has entirely disappeared and that it is not recurring, the immediate relief from anxiety afforded by the procedure must be necessarily tempered or restrained by the knowledge that the final verdict cannot be rendered until such a followup reveals that she is free of recurrence. On the other hand, the relief afforded by the disappearance of the mass may tempt the most disciplined but sympathetic physician to succumb to his patient's joy and fail to impress her adequately with the need for a followup and the stern necessity of withholding final judgement until such followup has been satisfactorily completed. All these psychological gambits are weaknesses in the method and constitute potential pitfalls permitting the escape of patients from followup or delay in initiating definitive treatment if unsuspected cancer is found.

The authors of recent articles on the subject have tended to be obscure in their descriptions of the type of breast lesion for which this procedure is suitable. Thus, a recent article describes its use not only in solitary lesions of the breast but also in cases of "fibrocystic disease of both breasts" as both a diagnostic and therapeutic procedure. Another author qualifies this by saying that it should only be used as a procedure to differentiate between solid and cystic lesions with the added proviso that cystic lesions, if they meet certain criteria which have been already stated, may be adequately and safely treated by aspiration.

In the case of solitary or dominant lumps in the breast, experience over the course of years has found that they are malignant or harbor malignancy in ap-

proximately one out of ten cases. It has been universally accepted that routine excision or surgical biopsy of such lesions is the safest and, according to some, the only procedure worth considering. It seems doubtful that the introduction of aspiration as a preliminary diagnostic step would do anything but tend to reduce the efficiency of this principle.

In the case of diffuse fibrocystic disease of the breast, the illuminating studies of Warren have shown that the cancer attack rate for women with this entity is 4.5 times greater than the rate for all women. The highest malignant potential was in the 30 to 49 year group in which a cancer rate 11.7 times the rate expected in the average female population was found. Based on these findings, it would seem imperative in fibrocystic disease of the breast in general, and in cases falling in the age span of highest attack rate especially, that a generous sample of breast tissue be obtained for careful microscopic study. Any procedure which tends to soothe or allay the logical concern of these patients or their physicians about the presence of unsuspected cancer or the possibilities of developing cancer in admittedly abnormal breast tissue would seem unwise. Granted, as many have maintained, that the cysts themselves are rarely malignant and the aspiration of such cysts does not cause trouble, it must conversely be stated however that such aspiration does not produce anything on the positive side of the ledger either, and that the soil in which these cysts are growing and developing is apparently soil which is favorable for the production of breast cancer. The opportunity for sampling this soil afforded by an indication for excision of an abnormal lump should never be neglected. Almost all surgeons who do a considerable amount of breast surgery, will recall cases of entirely unsuspected minute, early, and therefore presumably highly curable cancer which were coincidentally or accidently uncovered by such an exploratory excision of breast tissue in cases of supposedly benign fibrocystic disease.

It has been stated that in the past 25 years a great part of the improvement which has been recorded in the treatment of breast cancer has been due to the inclusion in most series of breast cancer cases of minute, early, border-line, and on the whole, therefore, highly curable cancers, some of which have been of low virulence. Any procedure which would tend to increase the reluctance of the surgeon to operate upon seemingly benign but definitely pathological breast conditions will tend to neutralize this factor and will work against early detection and definitive early treatment of breast cancer. Finally, since there is no reason to pay any attention whatsoever to lumps in the breast except for (1) the fear of cancer, and (2) the relief of pain, and since mammary cancer, the most frequent malignancy of the female, exacts a fearful toll of between 50,000 and 60,000 lives each year, any procedure in the treatment of breast diseases which has as its prime recommendations not the ferretting out of early cancerous conditions in the breast, but rather features designed primarily to cater to the patient's sensibilities and convenience has no honored place in the stern discipline of the fight against cancer.

Aspiration might conceivably be employed as a therapeutic and quasi-diagnostic method in patients with multiple recurrent benign fibrocystic disease of the breasts provided that a breast sample has previously and recently been obtained by surgical excision, and provided that the rules for its safe conduction, here previously mentioned, are strictly adhered to.

George Benton Sanders, M.D.

Manuscript Memos

Manuscripts should be submitted in duplicate to the Journal of KSMA, an original copy and one carbon, and typed with double spacing. Maximun length of an article should not exceed 4500 words, and the Board of Consultants on Scientific Articles prefers that they be briefer than this when possible.

Footnotes and bibliographies should conform to the style of the Quarterly Cumulative Index Medicus published by the American Medical Association. This requires in the order given: name of author, title of article, name of periodical, with volume, page, month—day of month if weekly—and year.

All scientific material appearing in the Journal is reviewed by the Board of Consultants on Scientific Articles. If illustrations are submitted with a paper, the Journal will assume the cost for the first three one-column width half tones. The cost of additional illustrations will be borne by the essayist.

Arrangements for reprints of an article should be made directly with the publisher of the Journal, Mr. J. G. Denhardt, Times-Journal Publishing Company, Bowling Green, Kentucky.

Please mail your scientific articles to the Journal of the Kentucky State Medical Association, 620 South Third Street, Louisville 2, Kentucky.

President's Page

Our American Medical Association

You will hear, occasionally, well qualified physicians, scientifically speaking, deride the Journal of the American Medical Association and criticize the AMA in general terms. We had this experience recently. Though prominent in a specialty group, this man's lack of knowledge relative to medical organizational work—and its value to him—was distressing.

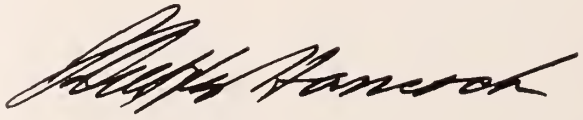
The American Medical Association is the official spokesman for the physicians of the United States. It is to the interest of everyone of us to support it for through it we can accomplish things that are impossible when we work as individuals.

It is only rarely that a physician parts ways with his national organization because of some personal grievance. The usual cause is a lack of information regarding the objectives and accomplishments of that organization.

The aim of the American Medical Association is the betterment of the health of the people of the United States. If it seems political at times it is because matters of health require legislation and legislation is dependent upon politics. Our A.M.A. has fought hard to maintain those principles practically all of us deem necessary for the advancement of the care of the sick—namely free choice of physicians, fee for service charge, independence of medical education from government control, proper appraisal and care of medical indigents, and regulation of public health measures.

The A.M.A. publishes numerous journals, its laboratories impartially evaluate the safety and efficiency of new drugs, it exposes quackery, it helps to finance medical school operating expenses, it aids in interne and residency programs, it encourages numerous committees working on the problem of the chronic diseases, it supports voluntary health insurance, and it offers library and information facilities that are unexcelled. These are only a few activities of our American Medical Association.

Each of us should consider it a privilege as well as an obligation to be a member of such a team.



PRESIDENT

ORGANIZATION SECTION

AMA Names Dr. Clark Bailey to Office of Vice-President

Clark Bailey, M.D., of Harlan, a past president of the KSMA and a delegate to the AMA for nine years, was elected vice-president of the American Medical Association, defeating McKinnie Phelps, M.D., of Denver, at the closing session of the AMA House of Delegates in San Francisco in June.

President of the Kentucky State Medical Association, J. Duffy Hancock, M.D., Louisville, extended his congratulations to Dr. Bailey, saying, "Kentucky has again been signally honored by the AMA in the selection of Clark Bailey as vice-president. This recognition was based upon his solid contribution to organized medicine and indirectly recognizes all who have worked with him."

Dr. Bailey has rendered many years of conscientious service to his local community, to his state and to the nation. Currently he is serving as a member of the Legislative Committee of the AMA and is also a member of the Committee for Study of Medical Care of Industrial Workers, a Sub-Committee of the Council of Medical Service.

Within his state organization, Dr. Bailey has served as a member of the Blue Shield Board of Directors since its organization. He is chairman of the KSMA Committee on the Corporate Practice of Medicine, and a member of the KSMA Legislative Committee. He is currently serving as a member of the Board of Directors of the Rural Kentucky Medical Scholarship Fund.

A leader of organized medicine and civic activities in his local community, Dr. Bailey is a past president of the Harlan County Medical Society, president of the Harlan County Board of Health, past president of the Harlan Kiwanis Club, and a member of the Board of Trustees of the Pine Mountain Settlement School. He is also on the Board of Trustees of Georgetown College.

Timothy V. Hartnett, Louisville, has been named full-time chairman of the Tobacco Industry Research Committee, according to a recent release from the industry. The committee was formed this year by 15 leading cigarette manufacturers and related industries to sponsor independent research into all phases of tobacco use and health.

House Votes Dr. Elmer Hess New AMA Pres.-Elect



Dr. Hess

Elmer Hess, M.D., of Erie, Pennsylvania, one of the nation's outstanding urologists and chairman of the AMA's Council on Medical Service, was selected as the 109th president-elect of the American Medical Association by a unanimous vote of the House of Delegates, June 24, during the Annual Meeting in San Francisco.

The House re-elected George F. Lull, M.D., Chicago, secretary and general manager, and James R. Reuling, M.D., Bayside, New York, and Vincent Askey, M.D., Los Angeles, speaker and vice-speaker, respectively.

Two other physicians nominated for the office of president-elect were Harvey B. Stone, M.D., Baltimore, and Edwin S. Hamilton, M.D., Kankakee, Illinois. A number of KSMA members will remember hearing Dr. Hess, the new president-elect, as a featured guest speaker at the 1953 County Society Officers' Conference held in Louisville, March 5.

Dr. Hess has long been active in the medical affairs of Pennsylvania and the AMA. He has served as president of his county medical society, his state medical society, the Pan-American Medical Association Section on Urology and the American Urological Association. He will take office at the next annual meeting in Atlantic City June 6-10, 1955.

Fourth Diabetes Drive Planned For November 14 to 20

Detection of the estimated 15,000 unknown cases of diabetes in Kentucky is the object of the 1954 Fourth Annual Diabetes Detection Drive to be held from November 14 to 20, under the sponsorship of the KSMA as a public service in cooperation with the American Diabetes Association.

According to a recent announcement by Carlisle Morse, M.D., Louisville, chairman of the KSMA Diabetes Committee, each member of the KSMA will be asked to give a free urine

sugar test to any person requesting it during the week of the drive. Materials needed for testing will be provided by the American Diabetes Association. During 1953, over 35,000 free tests were made, Dr. Morse said.

"The success of a state-wide drive rests largely with the Diabetes Committee of each county medical society in efficiently organizing the drive on a local level so as to assure maximum cooperation by KSMA members and full participation by the public," the chairman stated. "A publicity campaign on a state-wide level will supplement the efforts of the county medical societies," he added.

The KSMA holds the unique record of being the only state medical association sponsoring a state-wide diabetes drive, Dr. Morse pointed out. In the past the lives of over 500 persons have been saved for useful, happy activity through the annual detection drive. The purpose of the annual campaign is to discover the unknown victims of diabetes that they may enjoy the benefits of the control measures modern medicine now provides.

Other members of the KSMA Diabetes Committee are:

George N. Burger, M.D., Covington; Frank H. Moore, M.D., Bowling Green; Herald K. Bailey, M.D., Ashland; Franklin B. Moosnick, M.D., Lexington; Charles B. Billington, M.D., Paducah;

William R. Parks, M.D., Harlan; Guinn S. Cost, M.D., Hopkinsville; Marcus A. Coyle, M.D., Springfield, and Stanley Simmons, M.D., Louisville.

Dr. Howard Re-Elected Chairman of Rural Scholarship Board

C. C. Howard, M.D., Glasgow, was re-elected chairman of the Board of Trustees of the Rural Kentucky Medical Scholarship Fund, and G. L. Simpson, M.D., Greenville, was named vice-chairman at a meeting of the committee in Louisville, June 17.

It was reported that as of June 16, 1954, 206 loans, amounting to $151,096 have been granted to 80 students. A new type of loan will be granted in the future to students who agree to return to practice in rural counties for each year they receive aid. Under the new plan, $5,000 instead of $3,200 will be granted during the four years.

The committee voted to change the method of granting loans from the present one based on physician-population ratios by counties to a system based on centers of population. The Board defined rural areas which are approved for locations for practice of graduates aided by the fund to be those areas not within 20 miles of a city having a population of 50,000 or greater nor within 10 miles of a city having a population between 5,000 and 50,000.

Other officers re-elected at the meeting are Bruce Underwood, M.D., Louisville, secretary-treasurer; J. Murray Kinsman, M.D., Louisville, liaison officer; Mr. Virgil S. Steed, Louisville, consultant; Mr. George D. Caldwell, Louisville, representative of fiscal agent, Louisville Trust Company, and Mr. Raymond F. Dixon, Louisville, executive secretary.

Out-of-State Speakers Highlight November 1st Meeting

An all day and evening meeting of the Eye, Ear, Nose and Throat Section of the Kentucky State Medical Association is planned for November 1, 1954, in Louisville, according to Ralph A. Gettelfinger, M.D., Louisville, president.

Guest speaker in Ophthalmology will be Charles E. Iliff, M.D., Baltimore, who will present papers on the following subjects: "Dacryocystorhinostomy Surgery," "Ptosis Surgery," and "Tumors of the Lids, Their Diagnosis and Treatment."

Ben H. Senturia, M.D., St. Louis, Missouri, will be the guest speaker in Otolaryngology. He will discuss "The Cause and Treatment of the Itchy Ear" at the afternoon session, and "The Adenoid Problem" at the dinner meeting.

The Eye, Ear, Nose and Throat Section had originally planned to meet with the Kentucky State Medical Association during its annual session in September. Because there was a conflict of meeting dates with the Academy of Ophthalmology and Otolaryngology in New York, the date was changed to November, Dr. Gettelfinger said.

Dr. Hancock Appoints New McDowell Home Committee

The 1953 session of the House of Delegates authorized the dissolution of the McDowell Corporation. This has been effected and the secretary of state has so announced.

With the dissolution of the corporation and its board of directors, it became necessary for J. Duffy Hancock, M.D., Louisville, president of the KSMA, to name a committee to operate the shrine at Danville.

Dr. Hancock announced the appointment of the following: Charles A. Vance, M.D., Lexington, chairman; Irvin Abell, M.D., Louisville;

Laman A. Gray, M.D., Louisville; Leon Higdon, M.D., Paducah; E. M. Howard, M.D., Harlan; Francis Massie, M.D., Lexington; T. O. Meredith, M.D., Harrodsburg, and Russell Starr, M.D., Glasgow.

Dr. Harter Replaces Chm. Beard On Nominating Committee

With the resignation of Marion F. Beard, M.D., Louisville, as chairman of the KSMA Nominating Committee, John Spencer Harter, M.D., Louisville, was chosen to fill out the unexpired term.

Under Chapter V, Section 5 of the KSMA By-laws, it is provided that the Nominating Committee will report one or more nominations, for each of the KSMA officers to be elected, at the first meeting of the House of Delegates which will be September 20. At the second meeting of the House, September 22, the officers will be voted on.

Dr. Beard's resignation was made necessary because he will present a paper on September 16, in Paris, France, before the International Society of Hematologists entitled "Serum B12 Concentrations in Leukemia." Since leaving Quebec on July 14th, Dr. Beard has met with hematologists in England and has toured Germany and Italy.

Delegates to the 1954 meeting will receive a list of ten names, nominated by Speaker Charles A. Vance, M.D., prior to that meeting. At the second session of the House, the Delegates will select five of the ten, which will comprise the 1955 Nominating Committee.

AMA Meeting Attended by 36 Kentucky Physicians

Thirty-six Kentucky physicians were among the more than 12,000 M.D.s who registered for the 1954 Annual Meeting of the American Medical Association in San Francisco, June 21 to 25. Total registration was approximately 35,000.

Leading the group from Kentucky, in addition to AMA Delegates, Clark Bailey, M. D., Harlan, and Bruce Underwood, M.D., Louisville, were KSMA President-Elect Clyde C. Sparks, M.D., Ashland, and Treasurer Woodford B. Troutman, M.D., Louisville.

Mrs. Clyde Sparks, president of the Woman's Auxiliary to the KSMA, attended the Annual Meeting of the Woman's Auxiliary to the AMA. KSMA members listed in the "Daily Bulletin" as having registered are:

June 20, 1954

Maurice Nataro, Louisville; Robert S. Nelson, Ft. Knox;

June 21, 1954

Clark Bailey, Harlan; R. G. Boles, Louisville; Ellis M. Bond, Raceland; William H. Bryant, Glasgow; M. M. Hall, Campbellsville; Earl P. Oliver, Scottsville; Woodford B. Troutman, Louisville; Bruce Underwood, Louisville;

June 22, 1954

Morgan R. Colbert, Louisville; M. R. Cronen, Louisville; James W. Davis, Louisville; Richard E. Doughty, Louisville; Clifton G. Follis, Glasgow; Robertson O. Joplin, Louisville; Charles F. Long, Elizabethtown; Mary C. Long, Louisville; Ralph D. Lynn, Elkton; Thomas J. Overstreet, Lexington; T. M. Perry, Jenkins; Everett L. Pirkey, Louisville; J. R. Popplewell, Jamestown; Russell R. Rudd, Fulton; Douglas E. Scott, Lexington; Lillian H. South, Louisville; Clyde C. Sparks, Ashland; Carl Wiesel, Lexington;

June 23, 1954

Everett H. Baker, Louisville; Oren A. Beatty, Louisville; Irwin H. Cutler, Louisville; O. W. Frickman, Newport; William H. Hagan, Louisville; A. Clayton McCarty, Louisville; A. A. Shaper, Louisville; Joseph J. Wynn, Louisville.

Association Formed by Physicians Trained at General Hospital

The Association of Ex-Residents, Fellows and Interns of the Louisville General Hospital and the University of Louisville School of Medicine was organized officially at a dinner meeting June 8, 1954, at the Louisville Boat Club, according to D. P. Hall, M.D., of Louisville, who was elected the first president

Other officers named were Robert Alberhasky, M.D., vice-president, and Sam Clark, M.D., secretary. Hugh Williams, M.D., Elliott Podoll, M.D., Oscar Hayes, M.D., Malcolm Barnes, M.D., and James C. Drye, M.D., were elected to the Board of Directors. All live in Louisville.

It is requested that all physicians interested in becoming members of the association send their full name indicating the year or years of service with the hospital to Walter Coe, M.D., Louisville General Hospital, 323 East Chestnut Street, Louisville, Kentucky.

Approximately 200 faculty members, current residents and interns attended the organizational meeting. Speakers included J. Murray Kinsman, M.D., Howe Eller, M.D., Rudolph

J. Noer, M.D., A. J. Miller, M.D., R. Arnold Griswold, M.D., Walter Coe, M.D., W. O. Johnson, M.D., J. C. Drye, M.D., and Leonard Davidson, M.D., all of whom live in Louisville.

According to Dr. Hall, the object of the association is to promote the interest of the Louisville General Hospital and the welfare of those who receive professional training in it, to develop an esprit de corps in the House Staff and serve to maintain an interest in the hospital for those who have completed their training.

Dr. Martin Addresses Nation as 108th AMA President



Dr. Martin

"Physicians are duty-bound to keep themselves informed on public matters which deal with the medical welfare of the people," Walter B. Martin, M.D., Norfolk, Virginia, declared after taking office as the 108th president of the American Medical Association.

The inaugural ceremony, originating from the Palace Hotel in San Francisco, June 22, 1954, was transmitted over the American Broadcasting Company's nationwide radio network.

Dr. Martin asserted that "physicians must not be swayed by special groups or interests but only by consideration of the overall good of medicine and medical welfare of the people. Medicine's many problems cannot be settled by governmental fiat, or by an easy formula."

The AMA president pointed up the phenomenal growth in the "machinery of medicine" but deplored the fact that "the very success of medicine in a material way may now threaten the soul of medicine."

Dr. Martin was the featured luncheon speaker at the Fourth Annual County Society Officers' Conference in Lexington, April 15, 1954. The address he delivered there entitled, "How Can the County Medical Society Best Serve the Public?" is carried in this issue of the Journal as the Special Article.

Children are more likely to get contagious diseases at five years of age than any other time, according to a study made of 200 New York City children which was published by the AMA. Conclusions were based on a 12-year study of children from 125 families.

Admission Procedures to Kentucky Mental Hospitals Listed

Editor's Note: (The following material regarding admission procedures to state mental hospitals was obtained from Frank Gaines, M.D., Louisville, director of Mental Health, Kentucky State Department of Health.)

Admission by medical certification is a new type of procedure passed in Senate Bill No. 58 by the regular session of the Kentucky General Assembly this year.

Admission by Medical Certification

This serves as a simple method for admitting a patient to a state mental hospital with a minimum of formality but without jeopardizing the patient's civil rights and without loss of citizenship. Admission by Medical Certification is instituted by a relative or friend of a mentally ill person making application for his admission to the superintendent of a state mental hospital. The application must be accompanied by the certificates of two physicians that the patient is mentally ill and requires hospitalization. If, after admission, the patient requests his release and if the superintendent believes that release would be detrimental to the patient's best interests, the superintendent may institute proceedings for a court inquest as to the patient's mental condition. The patient will be represented by legal counsel at the inquest and may testify if he so desires. The Medical Certification procedure is designed for those patients who, because of their illness, lack sufficient insight or capacity to make responsible application for admission for themselves. This procedure should not be used when it is clear that it will eventually be necessary to resort to a regular court commitment, as in the case of litiginous, paranoid patients or overactive, disturbed patients. A special form devised for this procedure may be obtained from a County Health Officer, a state mental hospital, or the Department of Mental Health. The various other methods for admission to Kentucky state mental hospitals are:

Voluntary Admission

A patient may request in writing that he be permitted to enter a state mental hospital voluntarily, and agree to give the hospital superintendent a five day written notice of his desire to leave. If, in the opinion of the superintendent, it would be dangerous to release the patient upon his request, the superintendent may institute proceedings for a regular court commitment.

Health Officer's Emergency Admission

If a patient needs hospital admission quickly for reasons of severely disturbed behavior, any health officer may, simply by completing a certificate of examination, send the patient to a state hospital for observation for a fifteen-day period. Within this period, the superintendent will recommend further hospitalization or release.

35-Day Observation Admission

This is designed as an intermediate observation procedure. On the written certificate of examination by two physicians, the County or Circuit Judge may send a patient to a state mental hospital for an observation period of

35-days. Within this period, the superintendent will report to the court whether or not the patient may be discharged or needs to be retained in the hospital for further care. This may be used for patients who are of less of an emergency, who require further observation and examination, or will need to be in the hospital a relatively short time. It is possible that many patients who previously were admitted on a 35-day observation procedure may now be admitted by medical certification.

Regular Court Commitment

On the petition of the family or friends, two court appointed physicians examine the patient and then testify in court before a jury as to whether or not the patient is mentally ill. Upon the verdict of the jury that the patient is mentally ill, the judge may then commit the patient to a state mental hospital. Under a legal commitment, the patient loses his citizenship and certain civil rights which may only be regained after discharge from the hospital by restoration proceedings instituted in the court of commitment.

New Faculty Members Added to U. L. Medical School

Two new faculty members have been appointed by the University of Louisville School of Medicine, according to J. Murray Kinsman, M.D., Louisville, dean. They will begin their duties this fall.

Edmond F. Erwin, M.D., formerly a professor at the University of Arkansas School of Medicine, will be assistant professor of medical psychology at the medical school.

Leonard Light, M.D., will become assistant professor of medicine. He has been a member of the faculty at Wayne University College of Medicine, Detroit, Michigan.

M.D.s Aid Needed in Study of Polio Vaccine Trial

More than 600,000 children have completed three inoculations in the field test of the trial polio vaccine developed by Jonas E. Salk, M.D., of the University of Pittsburgh. The emphasis now shifts to the evaluation study of data gathered on poliomyelitis cases in the test groups, including those children in the first three grades who did not get vaccine.

Early diagnosis, prompt reporting and follow-up, and securing necessary epidemiological information and laboratory specimens are important factors in the evaluation, according to Thomas Francis, Jr., M.D., University of Michigan School of Public Health, director of the study.

Whole-hearted cooperation of practicing physicians is needed in this phase of the study, according to the release from the National Foundation for Infantile Paralysis. It is important that physicians in areas where vaccinations were not given notify health officers of cases occurring among children who participated in the trials and then migrated to another area such as a summer camp, the release stated. Local and state health officials also need information on participating children who received injections of Gamma Globulin.

Ky. Delegates Report on Action Taken by AMA House

Kentucky's delegates to the American Medical Association's Annual Meeting in San Francisco in June spent a busy four days participating in important policy decisions covering closed panel medical care plans; veterans' medical care, osteopathy and "fee splitting."

On the closed panel medical care plan the House referred the issue to the Judicial Council to investigate and report on not later than the next Annual Meeting.

The House accepted the Reference Committee on Legislation and Public Relations' report relative to veterans medical care. The report condemned the unscientific method of determination of service-connected disabilities.

The report of the Reference Committee on Insurance and Medical Service reaffirmed the policy on non-service-connected disabilities and commended the informational program carried out by the Committee on Federal Medical Services.

Four resolutions dealing with the osteopathic problem were presented to the House. No decision was taken on these resolutions pending action of the House of Delegates of the American Osteopathic Association relative to a recommendation that an "on the campus" study of schools of osteopathy be made. The AOA House of Delegates no doubt considered the recommendations when it met in July.

The House of Delegates reaffirmed its position in opposing "fee splitting," rebating or payment of commissions in any guise whatsoever, and in further opposing any mechanism that encourages this practice.

The House also approved a Board of Trustees report calling for discontinuation of the registration of hospitals by the Council on Medical Education and Hospitals and suggesting that the Joint Commission on the Accreditation of Hospitals be requested to undertake the registration of hospitals in addition to its present accreditation activities.

In his formal address before the House as AMA president, Edward J. McCormick, M.D., Toledo, strongly recommended that the medical profession take the "guess work" out of

medical costs by adopting a fee schedule on an area or regional basis. Dr. McCormick's recommendation was referred to the Board of Trustees.

Any KSMA member wishing detailed information on any action taken by the AMA House of Delegates is urged to write the Headquarters Office which will be glad to supply the requested information.

Meeting of 12th and 15th Districts Attended by 100

Approximately one hundred physicians and their guests attended the afternoon and evening sessions of the joint meeting of the Twelfth and Fifteenth Councilor Districts held at Cumberland Falls, July 15, according to Garnett Sweeney, M.D., Liberty, 12th district councilor, and Edward Wilson, M.D., Pineville, 15th district councilor.

J. Duffy Hancock, M.D., Louisville, president of the KSMA, was the featured guest speaker. Another highlight of the evening program was a talk by David Cox, M.D., Louisville, president of the Jefferson County Medical Society.

Participants of a Symposium on Cardiovascular Diseases included: George W. Pedigo, M.D., Louisville, Ralph Denham, M.D., Louisville, and W. Buford Davis, M.D., Louisville. Both councilors expressed themselves as being well pleased with the excellent attendance and the program.

Drs. Joplin, Pace, Simpson Named To Medical School Committee

Robertson O. Joplin, M.D., Louisville; J. Vernon Pace, M.D., Paducah, and G. L. Simpson, M.D., Greenville, have been named by J. Duffy Hancock, M.D., Louisville, to serve a three-year term on the Medical School Advisory Committee.

Members whose three years expire in 1955 are:

Karl Winter, M.D., Louisville, chairman

C. C. Howard, M.D., Glasgow

Charles A. Vance, M.D., Lexington

Members whose three years expire in 1956 are:

Clark Bailey, M.D., Harlan

J. T. Gilbert, Jr., M.D., Bowling Green

W. Vinson Pierce, M.D., Covington

The committee's fiscal year is from July 1 to June 30. The committee was authorized by the Council at the request of the 1950-51 KSMA President, Sam A. Overstreet, M.D., Louisville.

KSMA Members Appointed to New Commission on Patient Care

The Kentucky State Medical Association will participate in the newly formed "Joint Commission for Improvement of Patient Care" in Kentucky, according to J. Duffy Hancock, M.D., president.

In addition to four representatives from the KSMA, the Commission is made up of four from the Kentucky Hospital Association, two from the Kentucky State Association of Registered Nurses and two from the Kentucky League of Nurses.

A meeting of the new Commission was scheduled for Friday, July 23. Members appointed by Dr. Hancock are: Winfrey P. Blackburn, M.D., Frankfort; Joseph D. Heitger, M.D., Louisville; George H. Rodman, M.D., Greenville, and Dana Snyder, M.D., Hazard.

The American Medical Association is a participant of the "Joint Commission for Improvement of Patient Care" at the national level.

Executive Secretary Appointed

Norman Anderson, Dayton, Ohio, was recently appointed executive secretary of the Health and Welfare Council of Louisville, it was announced by Winston P. Harrison, council chairman. Since 1952 he has been associate executive secretary of the Dayton Health and Welfare Council.

SMA to Meet in St. Louis

The Southern Medical Association will hold its 48th annual meeting in St. Louis, Missouri, November 8-11, 1954, at the Kiel Municipal Auditorium, according to Alphonse McMahon, M.D., St. Louis, president.

Although arrangements for the meeting have not been completed, it is anticipated that the program plan followed for the past three years will be used at the meeting. Physicians who attended previous SMA meetings will recall the wealth of excellent papers presented before the 21 sections.

Conference Names New Officers

Sister John Miriam, administrator of SS. Mary and Elizabeth Hospital, was named the new president of the Hospital Conference of Metropolitan Louisville on June 11, 1954. She succeeds Wade Mountz, Louisville, assistant administrator of Norton Memorial Infirmary. Lewis F. Cook, assistant manager of the Veterans' Administration Hospital is the new vice-president.

Limit Summer Tonsillectomies

Kentucky physicians are urged by the Poliomyelitis Advisory Committee to limit to a minimum the number of tonsillectomies performed during the summer months. The Committee is pleased to report that apparently there has been a decrease in the number performed except for emergency or urgent cases and felt that physicians and hospitals of the area should be commended for this cautious attitude.

Appointments Made by Governor

C. C. Howard, M.D., Glasgow, and Hershell Murray, M.D., West Liberty, were re-appointed by Governor Lawrence Wetherby for a three-year term on the Hospital Licensure Council, from July 1, 1954, to June 30, 1957. Their terms had expired June 30, 1954. The appointment of Hospital Administrator will be announced at a later date. Names of three physicians were submitted by the KSMA for each position to the Governor for his selection and appointment to serve in these positions, as provided by KRS.

Color Medical Telecast Shown

The first transcontinental color medical telecast in history, a special report on cancer, was seen by physicians attending the 103rd annual meeting of the American Medical Association in San Francisco, June 21-25, 1954. A special screen provided a close-up view for an audience of 1,400 at the meeting.

The four-day program, sponsored by Smith, Kline & French Laboratories, was entitled "Tumors of the Kidney" and provided physicians with the most advanced information on the diagnosis and treatment of all types of cancer as well as the latest research reports in the field.

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KHA Elects New Board Chairman

The Kentucky Heart Association elected Woodford B. Troutman, M.D., Louisville, chairman of the board to succeed Morris M. Weiss, M.D., Louisville, retiring chairman, at the annual meeting of the association held at the Brown Hotel, Louisville, in June.

Guest speaker was Irvine H. Page, M.D., director of heart research at the Cleveland Clinic Foundation, and president-elect of the American Heart Association. Dr. Page discussed the extensive research being done on arteriosclerosis and the material advances which have been recently made.

Mrs. Bailey Given WA Honor

Mrs. Clark Bailey, Harlan, received national recognition by her election to vice-president of the Woman's Auxiliary to the American Medical Association during the San Francisco meeting of the AMA in June. Long active in KSMA activities, Mrs. Bailey served as president from 1950 to 1951. Currently, Mrs. Bailey is chairman of the Legislative Committee of the KSMA Woman's Auxiliary.

KSMA Membership Increases

The following physicians recently became members of the Kentucky State Medical Association as of June 22, 1954, and their names have been listed officially on the KSMA membership roster.

S. Pearson Auerbach, M.D., Louisville,
Sidney P. Edds, M.D., Burnside,
John W. W. Epperson, M.D., Owensboro,
J. Kenneth Harris, M.D., Louisville,
J. D. Redden, M.D., Covington,
Earl B. Rynerson, M.D., Winchester,
John T. L. Tcheng, M.D., Covington.

Phi Chi to Register Alumni

Alpha Alpha Chapter of Phi Chi Medical Fraternity will register alumni at a special booth in the Columbia Auditorium during the Annual Meeting of the KSMA. September 21-23, 1954. Alumni are urged to stop by the booth and register in order that records may be brought up to date and contacts re-established. An open house will be held by Alpha Alpha Chapter one evening during the Meeting. Alumni will be informed of details at a later date.

Amebiasis[1] a "Poorly Reported" Disease

Until serious complications arise, amebiasis may pass unrecognized and patients receive only symptomatic treatment.

Although amebiasis is a disease with serious morbidity and mortality, statistics on its incidence[1] are incomplete because its manifestations are not commonly recognized and consequently not reported.

"*Vague symptoms[2] referable to the gastrointestinal tract, such as indigestion or indefinite abdominal pains, with or without abnormally formed stools, may result from intestinal amebiasis. Not infrequently in cases in which such symptoms are ascribed to psychoneurosis after extensive x-ray studies have been carried out, complete relief is obtained with antiamebic therapy.*"

To prevent possible development of an incapacitating or even fatal illness and to eliminate a reservoir of infection in the community, diagnosing and treating[3] even seemingly healthy "carriers" and those having mild symptoms of amebiasis is advised.

Early diagnosis[1] is important because infection can be rapidly and completely cleared, with the proper choice of drugs and due consideration for the principles of therapy. For treatment of the bowel phase these authors find Diodoquin "most satisfactory."

For chronic amebic infections, Goodwin[4] finds Diodoquin to be one of the best drugs at present available.

Diodoquin, which does not inconvenience the patient or interfere with his normal activities, may be used in the treatment of acute or latent forms of amebiasis. If extraintestinal lesions require the use of emetine, Diodoquin may be administered concurrently. It is a well tolerated and relatively nontoxic orally administered amebacide, containing 63.9 per cent of iodine.

Diodoquin (diiodohydroxyquinoline), available in 10-grain (650 mg.) tablets, reduces the course of treatment to twenty days (three tablets daily). Treatment may be repeated or prolonged without serious toxic effect. It is accepted by the Council on Pharmacy and Chemistry of the American Medical Association. G. D. Searle & Co., Research in the Service of Medicine.



Endamoeba histolytica (trophozoite).

1. Hamilton, H. E., and Zavala, D. C.: Amebiasis in Iowa: Diagnosis and Treatment, J. Iowa M. Soc. *42*:1 (Jan.) 1952.

2. Goldman, M. J.: Less Commonly Recognized Clinical Features of Amebiasis, California Med. *76*:266 (April) 1952.

3. Weingarten, M., and Herzig, W. F.: The Clinical Manifestations of Chronic Amebiasis, Rev. Gastroenterol. *20*:667 (Sept.) 1953.

4. Goodwin, L. G.: Review Article: The Chemotherapy of Tropical Disease: Part 1. Protozoal Infections, J. Pharm. & Pharmacol. *4*:153 (March) 1952.

WASHINGTON NEWS DIGEST

Washington, D. C.—During the next three years the federal government expects to help finance the construction of thousands of new medical and dental facilities—diagnostic-treatment clinics, vocational rehabilitation centers, nursing homes, and chronic disease hospitals. Only three strings are attached: the facilities must be non-profit, they must be under medical and dental supervision, and local communities must raise part of the cost.

Legislation establishing the new program was enacted just as Congress plunged into its adjournment rush, and before it had come to final decisions on reinsurance and other major controversial bills in the health field.

The new operation was authorized by amending the Hill-Burton Act (passed in 1946 to assist hospitals) to permit grants to units that do not qualify as hospitals. Under the original Hill-Burton law, grants could be made to rehabilitation centers and diagnostic treatment clinics only if they were attached to hospitals. Grants could also be made to chronic disease hospitals. The new law authorizes help centers and clinics operating on their own, a provision Public Health Service expects to be of particular assistance to smaller communities. It also offers aid to nursing homes, which previously were not covered.

In the case of chronic disease hospitals, it is explained that the law offers two new inducements for construction. 1. Money is allocated to the state and earmarked for this particular type of hospital. 2. The federal government will be able to pay 50% or more in all cases, whereas under the old law the U.S. share was as low as one-third in some of the higher-income states.

Grants to clinics, centers, and nursing homes will have to wait on state surveys to determine priorities, according to U.S. hospital officials. However, if local sponsors take the initiative, grants can be processed immediately for chronic disease hospitals, as earlier Hill-Burton surveys have established their priorities. Failure of communities to construct chronic disease hospitals was one of the disap-

(Continued on page 640)





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WASHINGTON NEWS DIGEST

(Continued from page 638)

pointments of the first Hill-Burton program.

The first year's appropriation will be $37.4 million, increasing over the next three years until the total authorization of $182 million has been reached. The new projects in no way interfere with the regular Hill-Burton grants for construction of hospitals, for which $75 million is available this year.

The final flurry over the reinsurance bill was preceded by a concerted drive by the administration. The President himself interceded with insurance company officials, and Secretary Hobby agreed to amendments in an effort to satisfy the state insurance commissioners. The commissioners, who would have an important role in administering the reinsurance program, at first had flatly opposed it. President Walter B. Martin and other A.M.A. officials were called in for a discussion of reinsurance at the Department of Health, Education, and Welfare, and later Sherman Adams, assistant to the President, also invited Dr. Martin to a White House meeting on the same subject.

As expected, bills for a new program of medical care of military dependents were left stranded when adjournment time approached. Before he introduced his bill on the subject, Chairman Dewey Short of the House Armed Services Committee insisted that Defense Department estimate first year's additional cost of the program. The estimate was $67 million.

The military scholarships bill met the same fate—too much time taken up in drafting a version that would satisfy all executive departments. Under this plan the Defense Department would grant tuition-and-maintenance scholarships to medical and dental students, in exchange for pledges to spend one year in military service for every subsidized year of training. Both bills are certain to reappear next session.

For the current fiscal year, the Department of Health, Education, and Welfare has available $1,663,413,761. The appropriation bill is $10,904,500 more than the administration requested but under last year's budget of $1,927,432,261 (the decline explained by decreased public assistance grants to states). Public Health Service has $228,060,000 for its regular programs.

The California Medical Association presented a check for $100,000 to the American Medical Education Foundation, it was announced at the closing session of the AMA's House of Delegates meeting in San Francisco in June.

PHYSICAL EXAMINATIONS OF THE INJURED

(Continued from page 621)

of violence, deformity, pain, tenderness, rigidity and voluntary spasm, and loss of function are sought for in each particular region and, when found in a given part, the latter is noted for whatever additional examination is indicated by the specific nature of the injury. Even in the unconscious or comatose patient unable to give co-operation of any sort, few injured parts will be missed if all parts and all surfaces of the individual part are inspected and palpated.

9. Recording of the physical examination. The pertinent points in the history, general condition, character and extent of the individual injuries are recorded and additional diagnostic and therapeutic procedures ordered. In recording the physical examination, it is necessary in every instance to note the date and hour of the performance and all treatment administered during the process.

10. Transportation of the injured for further definitive treatment. The patient is not transported until the examiner is satisfied that his general condition permits, any accessible hemorrhage controlled, and all parts requiring immobilization properly splinted.

Summary

In summary, then, it may be said that the most important single feature in dealing with traumatic cases is adequate physical examination. The purpose of examination is to provide information as to the general condition of the patient and the extent and nature of the specific injuries, both of which are essential to rational treatment. This information can be reasonably complete on initial examination by systematized attention to certain common features concerned in all injury cases.

"The Modern Medicine Show" is the subject of the newest AMA exhibit which presents facts on so-called "medicine men" who have influenced the public into spending thousands of dollars in the past on quack medical cures and devices. This exhibit is now available for immediate bookings for public gatherings sponsored by state and county society meetings. For further information contact your KSMA Headquarters Office.

KSMA M.D.s Appear on TV

A number of KSMA physicians have appeared on the Marian Gifford WHAS television program in a summer series dealing with child care, produced with the cooperation and approval of the Louisville Pediatric Society, according to published reports in "News Notes" of the Jefferson County Medical Society.

Louisville physicians appearing on the various programs include: Harry Andrews, James Bruce, Cathyrn Handelman, N. I. Handelman, Lee Palmer, Elliott Podoll, and Edwin P. Scott.

More than 48,000 physicians contributed a total of $2,459,102 in unrestricted funds to the nation's medical schools last year it was reported in the American Medical Education Foundation's annual report. This represents an increase of more than 10,000 contributors over the previous year.

The present 10 per cent rate of cure for cancer could be increased to 25 even without any new discoveries, George E. Wakerlin, M.D., Chicago, reports in a recent issue of "Today's Health." The difference indicates the size of the educational problem facing the American people.

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HOW CAN THE COUNTY MEDICAL SOCIETY BEST SERVE THE PUBLIC?

(Continued from page 623)

pendents of service personnel. I would urge that each county society endeavor to inform fully its membership in reference to these policies and the reasons therefor. I am not urging that you necessarily agree with these policies but that your membership be informed.

Through the Hospital Survey and Construction Act, the Federal government has been aiding communities in building new hospitals and expanding old ones. There has been, over a period of seven years, a very worthwhile extension of good hospital facilities. At the same time the Federal Medicine Service through their expanding programs, are in competition with communities for not only doctors, nurses and scarce technical personnel, but also for patients, in the categories of service dependents and veterans with non-service connected conditions requiring hospital care.

The importance of helping to build up facilities in each community capable of caring for all the people of the community requiring care cannot be over emphasized. There is, of course, a small group of patients who will, because of the nature of their illness, have to be transferred to larger and more fully staffed institutions.

In the field of medical education, it has been our policy to oppose federal subsidy of the operating cost of medical schools. We recognize the financial need of the medical schools, and through the Medical Education Foundation we have moved to meet this need. While a considerable degree of success has been obtained, there is much yet to be done before the financial needs of the medical schools can be properly met. If each county medical society will actively back this movement and will persuade its membership that each one should contribute to this fund and thus repay part of the debt he owes his own school, this problem could be solved to the benefit of medical education and the honor of our profession.

Another very important activity that can be developed is a physician placement service. Our placement service in Virginia has been very successful in this regard. Over a period of several years, it has been placing physicians particularly in rural

areas and at present there are more physician applicants for placement than requests for physicians. This service is operated by the Virginia Council of Health and Medical Care. This Council is given generous support by our state society and several hundred of our physicians hold individual memberships. Along with this has gone a substantial number of medical scholarships offered by the State to deserving students with a provision that, for a limited number of years, they enter practice in areas where physicians are needed.

The most important service that the county medical society can render their community and the cause of medicine is to develop and maintain a high standard of medical care, to cultivate in its members a strong sense of moral responsibility to their individual patients and a fervid adherence to the ideals of their profession. In this day of rapid advances in the science of medicine, full use must be made of modern methods but other and more important attributes of medicine must not be lost. Medicine to meet the needs of the people and to satisfy their desires must be personal. We speak rather glibly of the physician-patient relation often without considering its meaning or how a proper relation is to be maintained. It is based on a mutual regard as between the physician and the patient, a regard by the physician for a particular individual with a medical problem that harasses him and a regard by the patient for the physician as a man of skill and sound training, an honest man, and a kind and understanding man. The development and maintenance of this type of relation can only be accomplished by the local society.

The fundamental policy of the American Medical Association is to advance the art and science of medicine and by so doing better the health of the public. As long as our policies are based on this concept and are not colored by self-interest, rancor or ambition, they will be good policies. The county society will best serve the public by aiding in translating these policies into full accomplishment in every county. The strength of the American Medical Association comes from its tap root that reaches down to the county society. We can never be greater than the composite strength of our local groups. A tree without roots which reach down deep

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into the soil will perish from drought, storm or flood. If our roots are deep and secure, we need not fear for the future of medicine.

Pertinent Paragraphs

The AMA's third Medical Public Relations Institute will be held September 1-2, at the Drake Hotel in Chicago. Designed primarily for public relations personnel and chairmen of state and county medical societies, this year's informal sessions are designed to stimulate the exchange of ideas in all areas of medical public relations.

Public spiritedness was exemplified by the 143 physician-members of the Jefferson County Medical Society who volunteered their services in the Polio Vaccine Field Trial during the month of June, stated C. Howe Eller, M.D., director of the Louisville-Jefferson County Board of Health. Names of the volunteers were listed in a recent issue of "News Notes", publication of the Jefferson County Medical Society.

Many waterless hand cleaners can cause or contribute to skin diseases of the hands and feet, according to an article published by the American Medical Association. The only really effective waterless cleaner of any value to the individual user is one based on solvents such as kerosene or benzine which at the same time are especially hazardous since they sensitize and irritate the skin.

Small boat accidents take about 1,200 lives each year, more than most communicable diseases, a physician reported in a recent issue of "Today's Health" magazine, published by the AMA. About 90 per cent of accident victims are men or boys and the supposedly careful 25 to 44 year old group accounts for as many deaths as the 15 to 24 group.

The 32nd annual scientific and clinical session of the American Congress of Physical Medicine and Rehabilitation will be held September 6-11, 1954, at the Hotel Statler, Washington, D. C. Full information may be obtained by writing to the executive office of the American Congress on Physical Medicine and Rehabilitation, 30 North Michigan Avenue, Chicago 2, Illinois.

The Arthritis and Rheumatism Foundation is currently offering fellowships in basic sciences related to arthritis. Deadline for applications is October 15, 1954. For more complete information and application forms write the Medical Director, Arthritis and Rheumatism Foundation, 23 West 45th Street, New York 36, N. Y.

Three awards totaling $1,000 are now being offered by the American Urological Association for the best essays submitted on the result of some clinical or laboratory research in urology. The first prize essay will appear on the program of the forthcoming meeting of the American Urological Association to be held in Los Angeles in 1955.

Material to furnish and operate the AMA meeting in San Francisco included more than 130,000 feet of electrical cable, 5,500 linear feet of draperies, 27,000 square feet of carpeting, 300,000 special cards, 400,000 different badges and thousands of folding chairs. More than 30 railroad baggage cars were used to ship the necessary items.

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News Items

John W. W. Epperson, M.D., has become associated with **Clint M. Lacy, M.D.,** Owensboro, for the practice of obstetrics and gynecology. Dr. Epperson, who is a native of Tennessee, received his education at the University of Maryland School of Medicine, graduating in 1943. He interned at University Hospital, Baltimore, Maryland. He received training in his specialty at Baltimore City Hospitals, Johns Hopkins Hospital, Baltimore University Hospital, and Ohio State University Hospital, Columbus.

A Kentuckiana chapter of the National Multiple Sclerosis Society was organized June 21, 1954, at a meeting in Louisville at the Henry Clay Hotel. **Oscar E. Bloch, Jr., M.D.,** Louisville, was the principal speaker.

Joseph D. Heitger, M.D., Louisville, received twin honors at the Indiana University Alumni Association centennial celebration in June. He was inducted into the Emeritus Club, composed of 50-year graduates. Also, Dr. Heitger was selected to accept the cup awarded to the class of 1904 for having the largest percentage of living members present for the activities.

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J. Campbell Cantrill, M.D., a native of Louisville, recently located in Georgetown for general practice. Dr. Cantrill was graduated from the University of Virginia Department of Medicine in 1950 and interned at the United States Naval Hospital, San Diego, California. He was recently discharged from service with the Navy.

John A. Hemmer, M.D., a native of Covington, opened an office in Louisville during the month of June where he will specialize in surgery. Dr. Hemmer is a 1946 graduate of the University of Cincinnati College of Medicine. He interned and took a surgical residency at Henry Ford Hospital, Detroit, Michigan.

Willis B. Blue, M.D., has opened an office in Henderson after a recent discharge from the Medical Corps of the United States Navy. He was graduated from Duke University School of Medicine, Durham, North Carolina, in 1951 and interned at the U.S. Naval Hospital, Pensecola, Florida. Dr. Blue was born in Union County in 1921.

Alfred M. Berg, M.D., who recently completed his training as Chief Resident in Surgery at the Veterans' Administration Hospital, Louisville, opened an office in the Francis Building, July 1st, for the practice of General Surgery. Dr. Berg was graduated from the University of Louisville School of Medicine in 1945 and interned at Morrisania City Hospital, New York City. He has taken four and one-half years of surgical residency at Veterans' Hospital and Norton's Infirmary, Louisville, and one and one-half years of radiological residency at Veterans' Hospital. During World War II and the Korean conflict, Dr. Berg served with the Medical Corps of the United States Army.

Elwood Eshman, M.D., Vanceburg, in Lewis County, was recently appointed by Governor Lawrence Wetherby to serve as a member of the Board of Regents at Morehead State College.

The 37th Annual Conference of the American Occupational Therapy Association will be held at the Shoreham Hotel, Washington, D.C., October 16-22, according to Margaret D. Clarke, publicity chairman. "Capitalize Your Assets," will be the theme of the general conference. For further details, contact your KSMA Headquarters Office.

A new drug, chlorpromazine, was found useful in relieving pain in patients who no longer obtained adequate relief from large doses of narcotics by five Illinois physicians who reported on their findings in a recent issue of the Journal of the AMA. Chlorpromazine was originally developed by a French laboratory to relieve nausea and vomiting.

County Society Reports

CALLOWAY

The monthly meeting of the Calloway Medical Society was held in the Chapel of the Murray Hospital on June 1, 1954. The meeting was called to order by A. D. Butterworth, M.D.

Physicians present at the meeting were J. C. Hart, Hugh Houston, C. C. Lowry, O. K. Mason, J. A. Outland, John Quertermous, Birdsall Carle, and Administrator Warming.

Dr. Outland read a letter from William F. Lamb, M.D., director of Local Health Service, in reference to a medical student being sent to Murray to work with the Health Center this summer.

Dr. Houston moved that Davis S. Colvin be asked to work with the Calloway County Health Center and Trigg County Health Center for the summer. The motion carried

Dr. Outland reported that Lad R. Mazera, M.D., director of the Division of Maternal and Child Health in the State Department of Health, would be willing to come to Murray to attend one of the staff meetings upon invitation. Dr. Houston moved that Dr. Mazera be invited to attend the next staff meeting. The motion carried.

J. L. Hopson, M.D., Secretary

GRANT

The Grant County Medical Society held a dinner meeting at the Hotel Donald June 30, 1954, with physician-members O. A. Cull, F. R. Scroggin, Claude C. Waldrop, and Virginia Kratz attending. Others present were Paul Harrison, M.D., of Owenton, and Mrs. Harrison, Mrs. Culland Scroggin, Mr. Everett Chipman and Dr. R. C. Kratz.

Dr. Harrison gave a short report of the Frankfort District Meeting. The Rabies Law was discussed. Members of the society filled out the physicians placement service questionnaire. The next regular meeting of the society will be in September.

Virginia D. Kratz, M.D.

SCOTT

The Scott County Medical Society held its regular monthly meeting on Thursday, July 1, 1954, at the John Graves Ford Memorial Hospital, Georgetown, with the following present: C. R. Lewis, A. F. Smith, E. C. Barlow, W. S. Allphin. Also Mrs. Teegardner, hospital superintendent, and J. Campbell Cantrill, M.D., Georgetown, who was accepted as a member.

H. V. Johnson, M.D., Secretary

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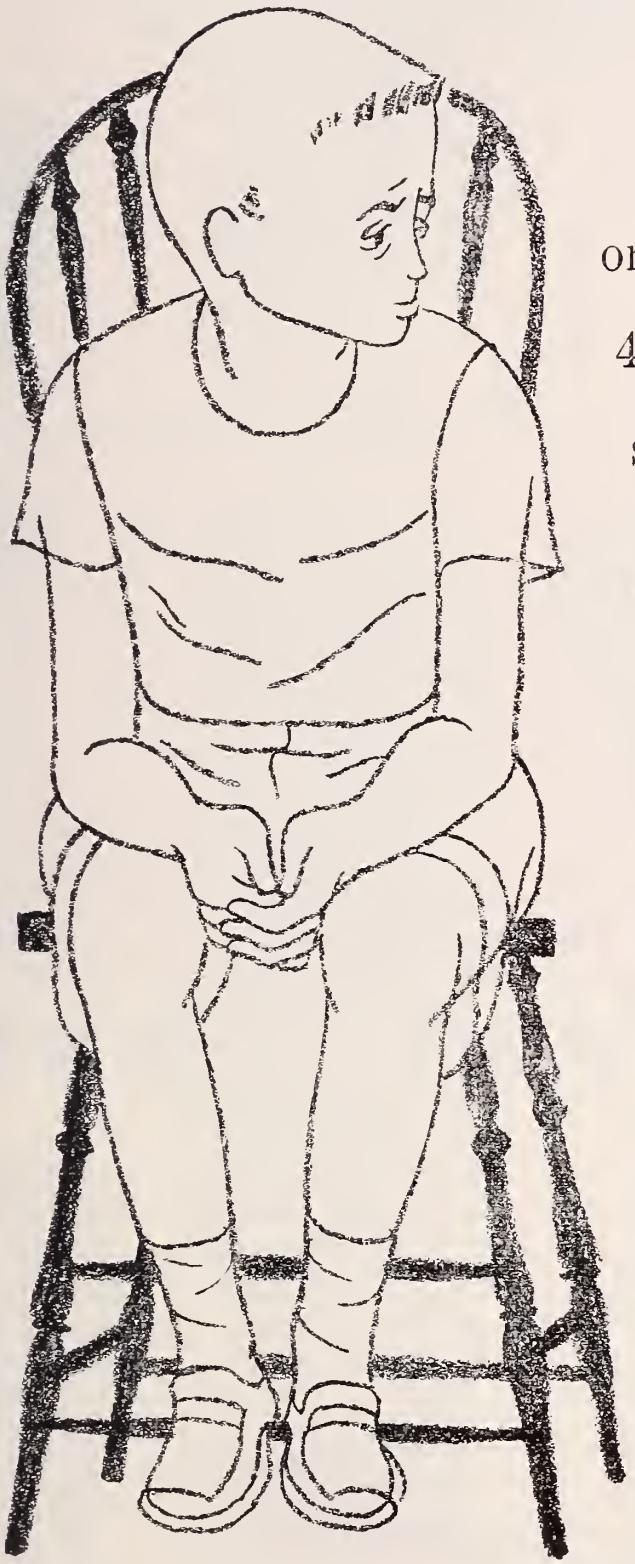
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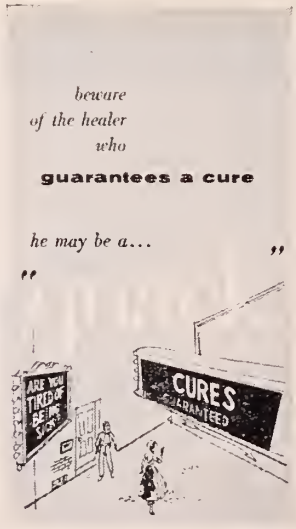
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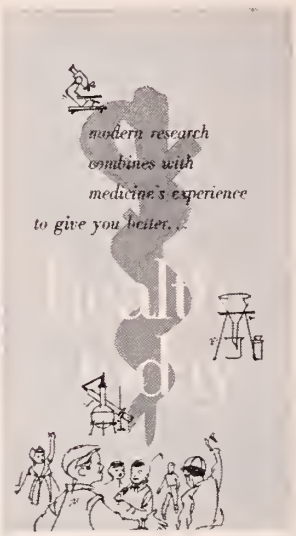
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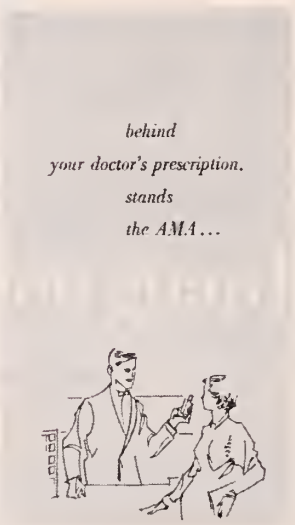
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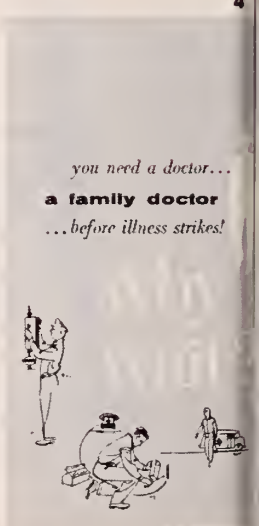
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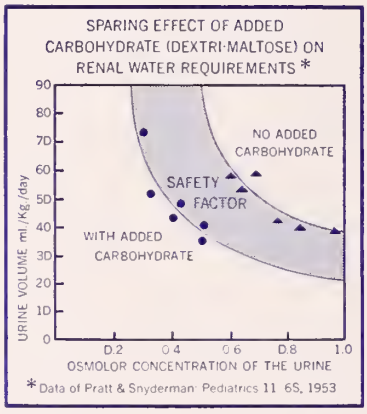
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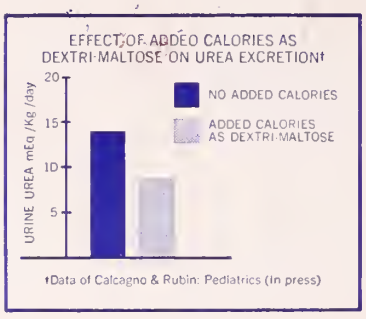
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1. Pratt & Snyderman: Pediatrics 11: 65, 1953; 2. Calcagno & Rubin: Pediatrics (in press); 3. Calcagno, Rubin & Weintraub: J. Clin. Investigation 33: 91, 1954; 4. Caake, Pratt & Darraw: Yale J. Biol. & Med. 22: 227, 1950; 5. Gamble: J. Pediat. 30: 488, 1947; 6. Rappaport: Am. J. Dis. Child. 74: 682, 1947.

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VOL. 52 SEPTEMBER, 1954 NO. 9

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References
(1) Kirby, W. M. M.; Waddington, W. S., & Doornink, G. M.: Antibiotics Annual, 1953-1954, New York, Medical Encyclopedia, Inc., 1953, p. 285.
(2) Finland, M., & Haight, T. H.: *Arch. Int. Med.* **91**:143, 1953.

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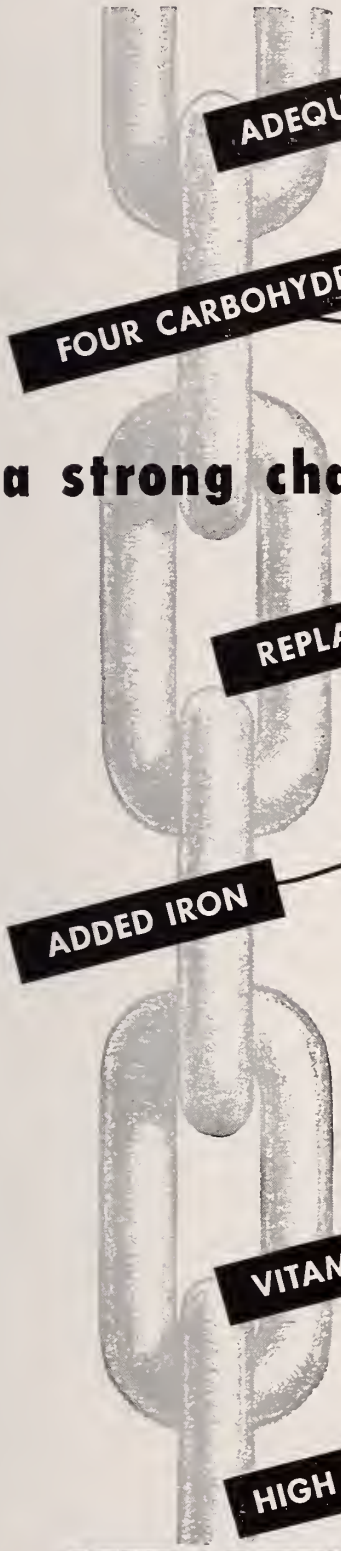
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1. Malleson, J.: Lancet 2:158 (July 25) 1953. 2. Goldzieher, M. A., and Goldzieher, J. W.: Endocrine Treatment in General Practice, New York, Springer Publishing Company, Inc. 1953, p. 23.

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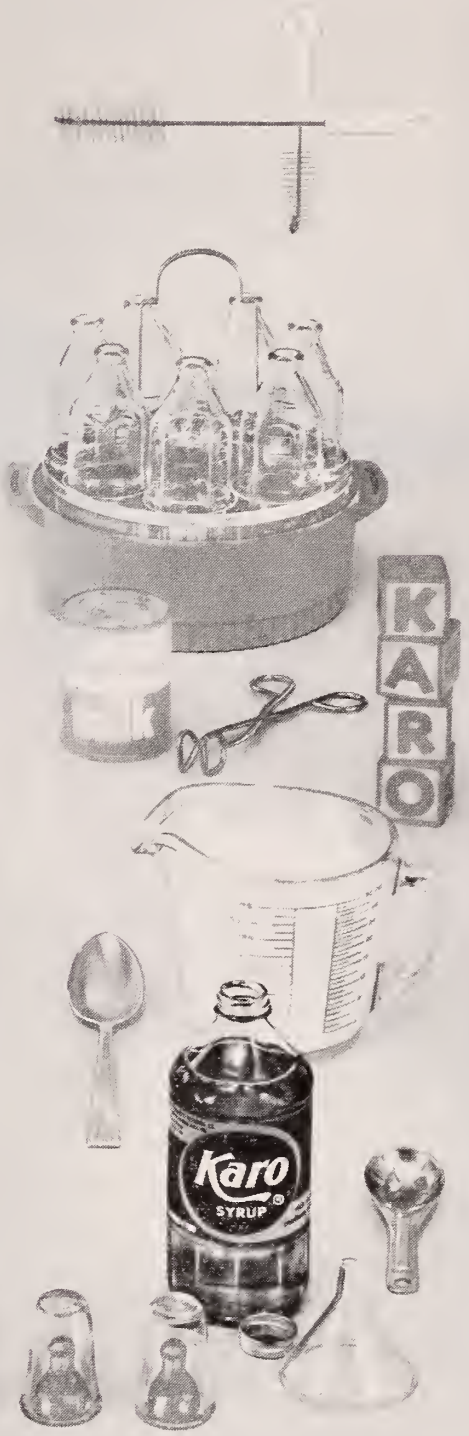
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1. Shuman, C. R., and Wohl, M. G.: Nutritional Aspects of Heart Failure, J. Clin. Nutrition 2:5 (Jan.-Feb.) 1954.

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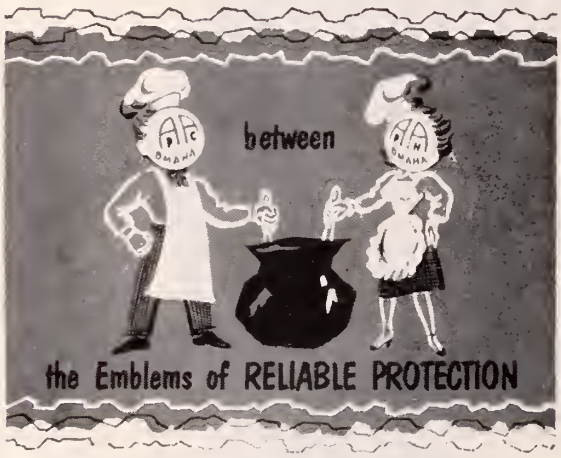
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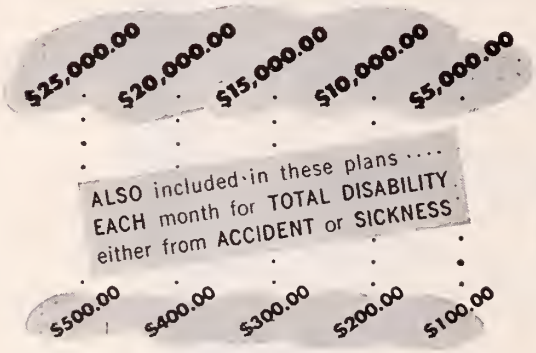
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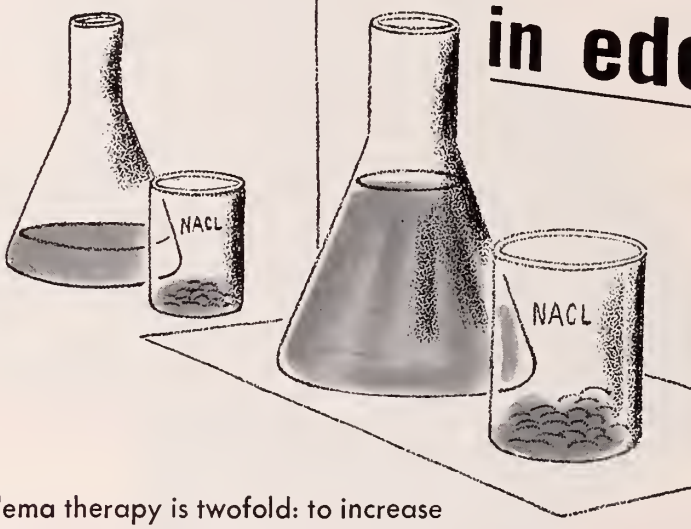
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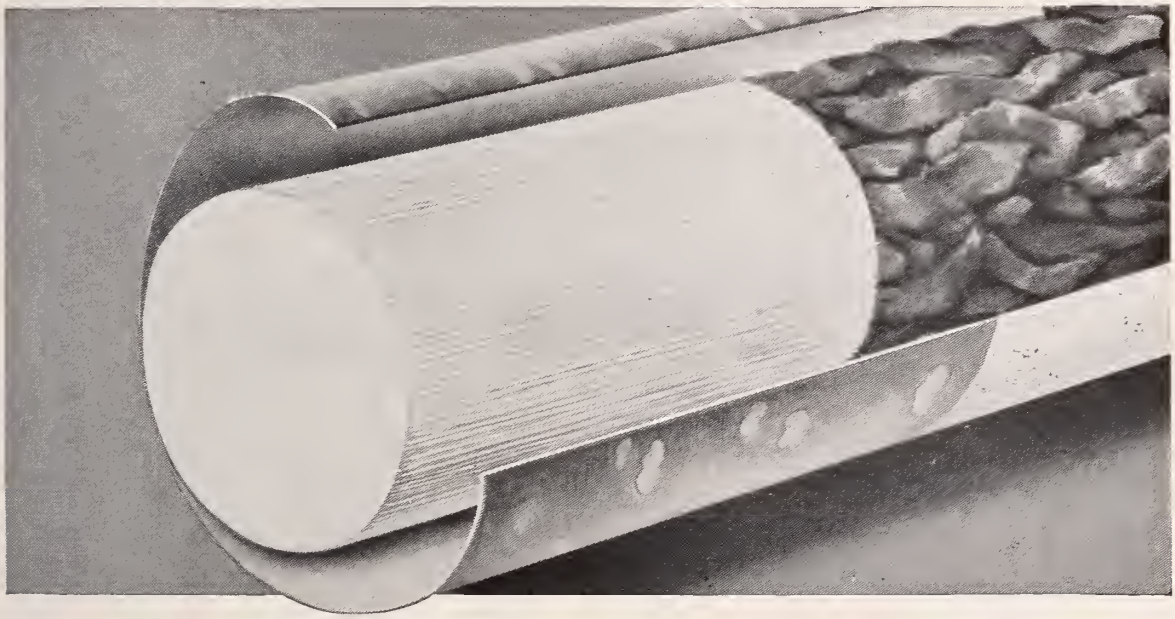
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Lumbar Hernias

WILLIAM T. SWARTZ, M. D.
Lexington

Lumbar hernias or dorsal hernias may appear as a parietal wall defect anywhere in the region below the twelfth rib, above the crest of the ilium, and lateral to the erector spinae group of muscles. They have been described under various names; Petit's hernia, Grynfeltt's hernia, costo-iliac hernia of Larrey, and supra iliac hernia of Huguier. These defects were described as early as 1672, when Barbette first suggested a hernia in this region[1].

The first authentic case was described in 1731 by De Garengeot who reported a female patient with a lumbar mass "the size of a nut" which was reduced at autopsy, thus confirming its diagnosis. In 1738, Petit described a strangulated hernia through the space that bears his name. In 1750, Ravaton successfully reduced at operation a strangulated lumbar hernia in a pregnant woman. In 1923, Watson collected 115 cases; he added 71 additional cases to his series in 1946[1]. In 1950, Thorek summarized 126 cases including two of his own[2].

Anatomy

Although defects in the lumbar musculature or aponeurosis may occur any place in the lumbar region, the two most frequent sites are the superior and inferior lumbar triangles. The superior triangle or triangle of Grynfeltt-Lesshaft, which is larger and more constant than Petit's, probably represents the most common site of origin for lumbar hernias. It is situated in front of and above the inferior triangle. This lumbo-costo-abdominal space assumes the shape of an inverted triangle. (Fig. B) The costal portion or base of the triangle is bounded by the lower border of the twelfth rib and serratus posterior inferior. The two sides of the triangle are formed anteriorly by the abdominal component, the posterior border of the internal oblique, and posteriorly by the lumbar component, the anterior border of the sacro-spinalis. Thus, the boundaries are readily brought to mind if the anatomical term "lumbo-costo-abdominal space" is used. The roof of this space is formed by the latissimus dorsi, the floor by the fascia transversalis. A weak point is situated immediately beneath the twelfth rib where the fascia transversalis is not covered by the external oblique and where it is perforated by the twelfth dorsal intercostal neuro-vascular bundle. (Fig. B)

The inferior lumbar triangle or triangle of Petit, forming an upright triangle, can

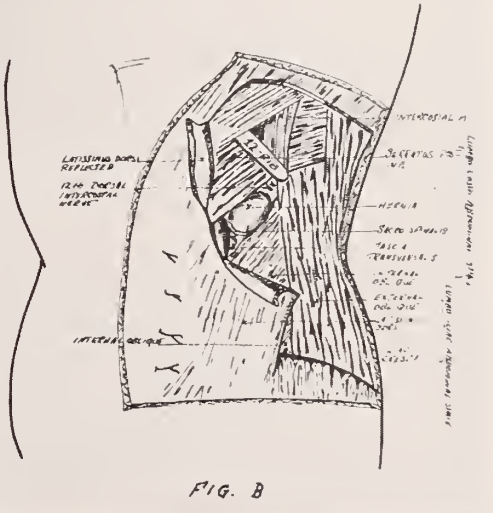


Fig. B Boundries of lumbo-costo-abdominal and lumbo-iliac abdominal space shown in detail.

be termed the lumbo-iliac-abdominal space. It may vary from considerable size to a slit-like defect, or be entirely absent. The base or iliac component is narrow, comprising the middle one-inch of the iliac crest. The free border of the latissimus dorsi forms the posterior or lumbar component as it passes obliquely in front of the external oblique muscle. The latter comprises the abdominal or anterior side of the triangle. A musculo-fascial floor is composed of the lumbo-dorsal fascia with underlying internal oblique and transversus abdominis. Unlike the superior triangle, no muscular structure forms a roof, the latter being merely superficial fascia and skin.

In addition to the superior and inferior triangles, herniation may occur through small congenital or traumatic defects in the musculature or aponeurosis of the region. The cutaneous branches of the second and third lumbar nerves, as they pass superficially, have been mentioned as a nidus for hernia.

Most authorities divide lumbar hernias into congenital and acquired types. The congenital forms, usually seen in infancy and occasionally bilateral, are very rare and are often associated with other congenital mal-developments. They may be due to any defect that weakens the lateral abdominal wall such as a mal-formation or developmental arrest of muscles, aponeurosis, ribs, vertebrae, or ilium. Watson discusses several cases of this type[2]. In one case reported by Brochardt in a fifteen months infant, a very large congenital hernia was found filling the entire space between the twelfth rib and crest of the ilium. Wyss reported a very large hernia presenting through the superior lumbar triangle in which the posterior serration of the external oblique and posterior one half of the transversalis were deficient. In their series Watson reports 20 and Thorek 23 of this variety.

Acquired hernias make up the vast majority of lumbar hernias occuring in adults. They may be traumatic or spontaneous. Traumatic acquired hernias are probably the most frequently encountered. They may follow severe, crushing injury or penetrating wounds. Post-operative flank incisions with difficult closure or faulty primary healing account for a proportionate number of this type. The deep abscesses of Pott's disease, coming to the surface through a weakness, originally accounted for most acquired hernias. Peri-nephric or liver abscesses, necrosis of the iliac crest, old hematomas, and even pregnancy with its increase in intra-abdominal pressure have been considered etiologic factors. A case is reported by Hancock[3] in which a man was thrown from the top of a derailed freight car and developed a traumatic lumbar hernia through Petit's triangle. Rishmiller[4] reported a traumatic hernia through Petit's triangle in a man in whom a portion of the ilium was broken off as both thighs were crushed by a car wheel.

Spontaneous acquired lumbar hernias occur most frequently after middle age. They are secondary to an acquired predisposition plus an indirect injury such as hard labor, lifting, coughing, or straining. This type occurs with about equal frequency in both major lumbar triangles. Obesity, old age and debilitating diseases are considered causative factors. The loss of fat that normally pads the neuro-vascular bundles may predispose to rupture. The fact that spontaneous hernias are twice as frequent in males as in females, confirms the etiological significance of laborious occupation in the variety.

Thorek recommends an anatomical classification of lumbar hernias[1]. This is based on the absence of peritoneum, extraperitoneal; or presence of peritoneum adherent to and following the descent of a viscus, paraperitoneal. A third type or intraperitoneal hernia is accompanied by and completely covered with peritoneum. These terms correspond to the extra-sacular, para-sacular, and intra-sacular variety of sliding hernias in general.

Although the anatomical classification advocated by Thorek is probably more descriptive, the former and older classification is still more frequently used.

SEX AND AGE INCIDENCE: Roughly 2/3 of the reported cases have been in males. This is probably due to the increased occupational activity, straining and trauma in the male population. The age incidence in cases reported by Watson varied from 1 year to 80 years of age, the greatest frequency occuring between 50 and 70 years[2].

Frequency of various types—
Watson

I	Congenital	20
II	Acquired-non-traumatic	70
	fall	10
	strain	10
	lifting	4
	injury	4
	spontaneous	42

III	Acquired traumatic	33
	large abscess	1
	Pott's disease	25
	Post-operative	7
	Total	123

Max Thorek

I	Congenital	23
II	Acquired-non-traumatic	57
	fall	7
	strain	11
	lifting	10
	injury	12
	spontaneous	17
III	Acquired traumatic	26
	abscess, including Pott's	19
	Post-operative	7
	Total	106

If we incorporate these two lists, we have the following:

Congenital	43	19%
Acquired N. T.	127	55%
Acquired T.	59	26%

Over half (55%) of the cases are considered acquired non-traumatic; of the remainder, slightly more than 26% were related to trauma and 19% had a congenital basis of origin.

A hernia sac is usually present. In large hernias this is located beneath the skin and superficial fascia. Smaller hernia may be beneath the internal or external oblique musculature. The sac may contain properitoneal fat, colon, small intestine, omentum or kidney. In Thorek's cases the origin was listed[1].

Sac contents:

Bowel	29
Fat	26
Colon	12
Kidney	6
Omentum	4
Appendix	2
Bone	1
Ovary	1
Stomach	1
Meningocele	1

Bowel was found in the sac of 29 cases, fat 26 cases, colon 12, kidney 6, omentum 4, appendix 2, bone, stomach, meningocele and ovary one case. Thus the sac content is usually bowel or properitoneal fat. Other adjacent structures are rarely encountered.

Subjective symptoms vary from a vague backache, dragging sensation, or lump in the flank to the colicky abdominal pains of mechanical obstruction. Hernias containing only fat usually cause no symptoms until they have attained considerable size. A palpable tumor mass in the flank makes the diagnosis relatively easy. The mass is usually reducible, tympanitic to percussion and productive of an impulse on coughing or straining. It may vary in size from 2.5 to 30 cm. Incarceration usually occurs in the spontaneous type. Strangulation has taken place in about 10% of the reported cases.

Differential flank masses include abscesses, Pott's disease, or benign tumors such as lipomas or fibromas. The absence of an impulse and defect and the lack of symptoms of incarceration aid in this differential.

The fundamentals of hernia repair in general apply to lumbar hernias. They should be repaired in all instances unless the general status of the patient mitigates against it. Thorek recommends a vertical incision extending from the 12th rib to the iliac crest. We have used an oblique incision beginning at the junction of the 12th rib and sacro-spinalis extending anteriorly below the anterior superior iliac spine. The sac if present should be freed and ligated after its contents have been reduced. If the hernia consists of properitoneal fat alone the pedicle should be ligated and the mass excised.

Various methods of parietal wall repair have been used. Dowd[3] turned a flap of fascia from the fascia lata and aponeurosis of the gluteus maximus and medius and sutured it to the lumbar fascia, latissimus dorsi, and external oblique. A smaller defect which persisted was then covered with a free fascial flap from the latissimus dorsi. (Fig. C) Rishmiller[4] split the latissimus and slid it over as a flap. Warbasse[1] imbricated the transversalis and reinforced it with a fascial flap turned up from the fascia lata and gluteus similar to that used by Dowd. Watson[2] favors imbrication of the transversalis. Thorek[1] has used tantalum mesh with success in very large defects.

Because of the lack of very dense fascial material suitable for suture anchorage, we feel that these defects should be closed with fascia. Fascia is a living suture of very great tensile strength. It will not cut through the musculo-fascial wall that it may be required to approximate and will form a living supporting structure in itself. We recommend multiple strips of fascia 1 to 1.5 cm. in width taken from the fascia lata of the thigh. These strips are readily obtained with the Mason stripper. The fascia is transfixed on itself on a large Gallie needle. Several strips imbricate the transversalis and approximate the ad-

jacent musculo-fascial walls without tension. In defects in which an approximation without tension is not possible the defect is closed with multiple fascial strips woven within each other in a basket weave technique. (Fig. 1,2,3) Very large defects may require large sheets of fascia, the edges of which are fingered and transfixed to the adjacent walls.

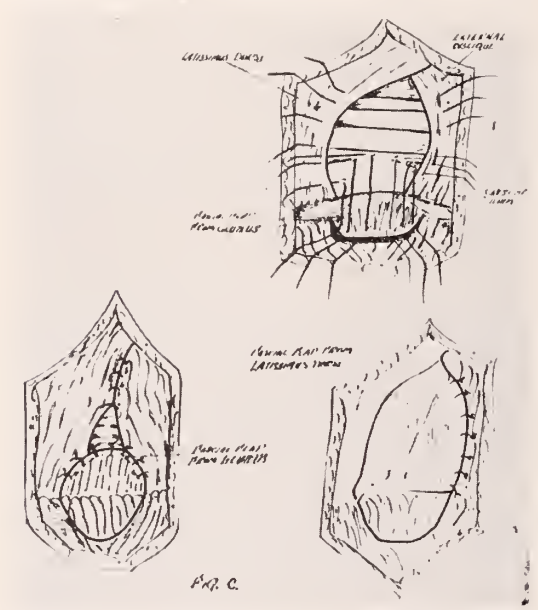


Fig. C Dowd turned a flap of fascia from the fascia lata and aponeurosis of the gluteus maximus, suturing it to the lumbar fascia, external oblique, and latissimus dorsi. The persisting defect is covered with a free fascial flap from the latissimus dorsi.

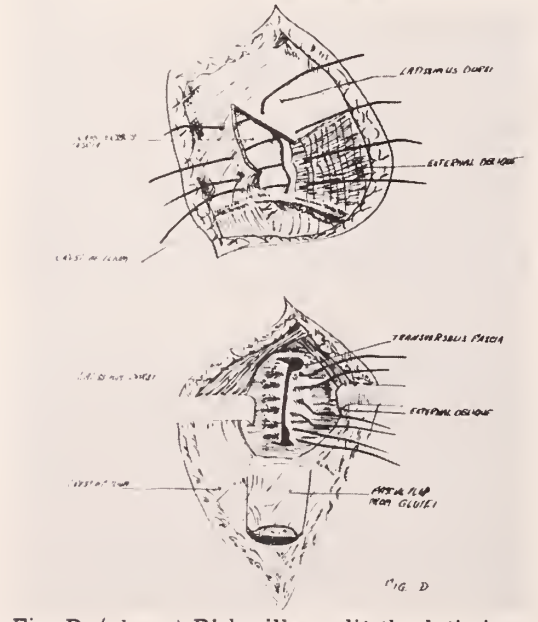


Fig. D (above) Rishmiller split the latissimus and slid it over as a flap. (below) Warbasse imbricated the transversalis and reinforced it with a flap turned up from the fascia lata and gluteus.

Case Reports

Case No. 1: B. H., a 50 yr. old white coal miner was admitted to the hospital with a three months history of lump in the left side. A mass the size of a lemon first made its appearance in the left lumbar region on lifting or straining and disappeared on lying down. There was considerable tenderness as the mass protruded. It had not increased in size since its onset and upon reduction the tenderness disappeared completely. There were no gastro-intestinal or genito-urinary symptoms. Past history included a weight loss of 18 pounds in the last six months and known hypertensive cardio-vascular disease.

Examination of the trunk confirmed a 4 cm. soft tender reducible mass in the left flank below and anterior to the tip of the 12th rib. On reclining a parietal wall defect could be palpated easily. Peristalsis was audible over the region.

Surgical repair was undertaken on 9/1/52 using Pontocaine, dextrose, and ephedrine spinal anesthesia. The patient was placed on the right side, the kidney rest elevated, and the entire left flank prepped and draped in the routine manner. A curved oblique incision was made parallel to the 12th rib and extended to the anterior superior spine. A three cm. defect was palpated in the floor of the superior lumbar triangle. Dissection revealed two defects in the transversalis fascia, one, two cm. in diameter just below the tip of the 12th rib, and the second smaller defect 2 cm. inferior to it. Pro-peritoneal fat protruded through both defects. This was excised and the bases transfixed. The defects were closed by imbricating the transversalis fascia upon itself with strips of fascia lata and incorporating adjacent musculo-fascial walls. (Fig. 1, 2). Anteriorly the conjoined wall was composed of the external oblique and internal oblique muscles, posteriorly the erector spinae and latissimus dorsi. The free ends of the fascia strips were transfixed upon themselves. (Fig. 2) A small central defect between fascial strips was reinforced by weaving a strip of fascia lata in a vertical manner thus reinforcing the roof of the superior lumbar triangle with a fixed, woven, fascial layer. (Fig. 3) Post-operative course was uneventful, the patient being discharged on the eleventh post-operative day.

This case represents an extra-peritoneal spontaneous acquired lumbar hernia. The congenital weakness or predisposition, weight loss of 18 pounds, and hard labor that is required of a coal miner are factors in the pathogenesis. Two separate defects were found in the transversalis fascia.

Case No. 2: A 29 yr. old white female housewife para V, gravid V, entered the hospital because of pain in the lower abdomen. A right nephrectomy (with an uneventful post-operative course) had been performed four years previously. Persistent dull aching pain, which had been present in the right flank since operation, had increased 4 months ago with the appearance of a bulge in the flank incision. The flank mass had gradually increased in size since its onset. She had lost 10 pounds in weight in the 2 months prior to admission. Past history included appendectomy in 1942, and a supravaginal hysterectomy in 1948.

A large, soft, somewhat tender, reducible mass was present in the right flank at the site of the nephrectomy scar. Peristalsis was not audible, although gurgling sounds could be heard on reduction of the mass. A hernial hiatus measured 8x6x6 cm.

At operation the previous flank cicatrix was excised and the incision carried down to the level of the flank musculature. A defect was found in the transversalis fascia measuring 4x8 cm. The lateral walls were formed by the external oblique and internal oblique muscles anteriorly, the latissimus dorsi and lumbo-dorsal fascia posteriorly. The sac contained pro-peritoneal fat. This was excised and its base transfixed. The lateral walls of the defect were attenuated and could be approximated as conjoined layers without undue tension. Two strips of fascia lata were used to approximate the lateral walls, incorporating the underlying transversalis fascia and obliterating the defect in it by imbrication. A third fascial strip was woven between the repair, incorporating the loops. Post-operative course was uneventful, the patient being discharged on her eighth day.

This case represents another type of extra-peritoneal hernia, the traumatic acquired variety. The previous surgical pro-

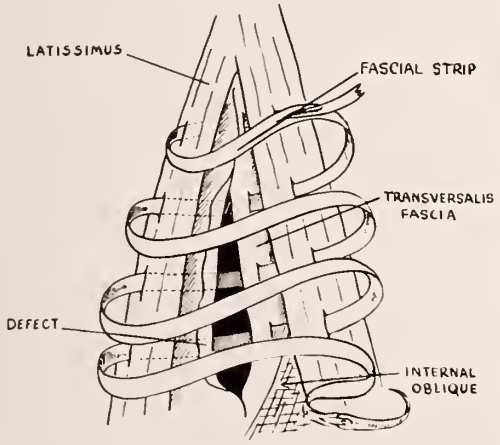


FIG. 1

Fig. 1 The transversalis and adjacent musculo-fascial wall are approximated without tension, the transversalis being imbricated upon itself.

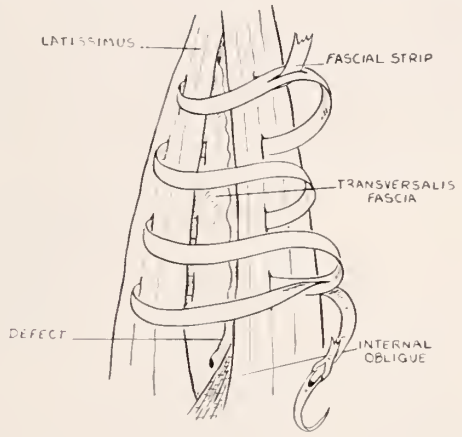


FIG. 2

Fig. 2 The free ends of the fascial strips are transfixed upon themselves.

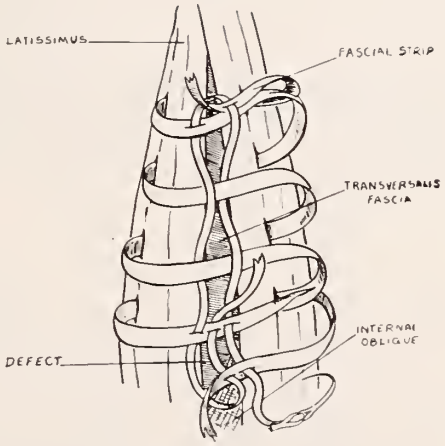


FIG. 3

Fig. 3 A small central defect between the fascial strips is reinforced by weaving a strip of fascia lata in a vertical manner, thus reinforcing the roof of the superior lumbar triangle.

cedure was no doubt the main etiological factor. A large extra-peritoneal sac was present. The repair, though modified somewhat, is similar to the previous case.

Summary

Two cases of lumbar hernia are presented. Both had origin through the superior lumbar triangle. Although these lesions may be congenital, occuring usually bilaterally, the majority of cases are acquired. These may be spontaneous (congenital weakness plus an indirect injury), or traumatic (secondary to surgery, severe trauma or infection). Thorek classifies them according to their peritoneal component, extra-saccular, parasaccular or intra-saccular. Sac contents vary but usually consist of properitoneal fat or bowel. Symptoms vary from vague aches to severe colicky pains. Strangulation occurs in about ten percent of the reported cases. The cardinal diagnostic triad includes a palpable, reducible, flank mass which transmits an impulse. Fundamentals of repair and various procedures are described. The author has used a type of repair in which fascial strips are taken from the thigh. With these the transversalis fascia is imbricated and the adjacent musculo-fascial walls approximated. This repair is reinforced by additional fascia woven between the previous loops and forming a solid, living, fascial support to the triangle.

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Pulmonary Tuberculoma

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In recent years solitary circumscribed lesions in the lungs discovered on roentgenologic examination have aroused considerable interest and stimulated investigation. These lesions, usually located peripherally, are asymptomatic, and frequently challenge the clinician in their diagnosis and management. Many advances have been made in the field of thoracic surgery since 1921 when Jacobaeus and Key first resected a solitary tuberculous lesion, and now the clinician has more effective means of managing these cases, whether they be tuberculous, neoplastic or otherwise.

Definition and Pathology

Tuberculoma, solitary focus, calcified abscess, Assman focus, Simon focus, and Ghon tubercle all represent focalization of a tuberculous pneumonia encapsulated by fibrous tissue. Greenville-Mathers defines a tuberculoma as a "solid caseous focus representing an undrained tuberculous abscess filled with inspissated caseous material from which tubercle bacilli can be recovered in large numbers." There is no specific distribution in the lung, nor do they show any tendency to occupy the apical and posterior segments of the upper lobes and the superior segments of the lower lobes for which the tubercle bacillus seems to have a predilection. Medlar, in his extensive work on the pathogenesis of tuberculosis, believes there are two possible reactions from the dissemination of the disease process; first, an area of pneumonia which heals either by complete resolution or scar formation; and secondly, the pneumonic process proceeds to caseation, necrosis and abscess formation. It is his opinion that the persistence of the unhealed necrotic lesions is responsible for relapses at a later date. Microscopically, patent bronchial communications with these necrotic foci are the means of spread to other areas.

Ackerman describes the gross appearance of tuberculoma as a subpleural, discrete, hard, round, mass with a dead white center and slightly yellow, glistening, overlying pleura. However, many variations of the lesion are found, depending upon the stage of healing. In the firm lesions, concentric layers of hyalinized connective tissue alternating with layers of calcification are found. In his reported cases, areas of caseation were observed in all le-

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sions, and in eleven a definite association with a small bronchus was demonstrated. The periphery of these lesions is composed of concentric layers of fibrous tissue with some hyalinization and infiltration of plasma cells and lymphocytes. Between the fibrous walls and the enclosed caseous material, there is a narrow zone of epithelioid cells with an occasional Langhans giant cell. At times, the caseous center liquefies so that a thin walled sac filled with tubercle bacilli and pus results. Most of these lesions are slow to calcify, and this fact, with patent bronchi, reveals the potential danger of the process.

Mahon and Forsee suggested three methods of development; first, an extensive, tuberculous caseous bronchopneumonia with positive sputum that cleared under treatment and resulted in a tuberculoma; second, an indistinct, faint, irregular, hazy spot with or without mild symptoms, negative sputum, and a lobular or bronchiolar pneumonia; third, a tuberculous bronchopneumonia which advanced to cavitation. Following compression therapy and bronchial obstruction these lesions often terminated in a shrunken cavity with retained caseous material. The majority of investigators favor a post primary origin for tuberculoma as there are no recorded examples of a primary lesion which attained the size of a tuberculoma with subsequent arrest. Black and Ackerman summarize the factors to support a post primary lesion; they are the large size, the subpleural location, the thick capsule, the presence of satellite nodules, the absence of bone, and the definite demonstration of separate Ranke's complexes in some of the cases. The exogenous route of infection is the most likely because of the absence of any further evidence of tuberculosis that would provide a hematogenous spread.

In dealing with solitary or coin lesions of the lung, the following chart will emphasize the importance of diagnosis and the incidence of malignancy. The source of the following material reported should be considered, because the cases found in sanitoria will be mostly benign and those in large cancer clinics will show a higher incidence of malignany.

(See table below)

Symptoms and Laboratory

Due to their small size and peripheral location coin lesions rarely produce symptoms. In the 18 cases reported by Ackerman and Black, six cases had minimal or no symptoms and the remainder had complaints indicative of a pneumonic process. In 15 of the cases questioned, six gave a positive history of tuberculous contact. Only two cases had demonstrable physical findings and rales. Three out of 15 cases examined had positive sputum and six out of eight had positive skin tests. Mahon reported 70% positive skin tests in his series of 55 cases.

Roentgenograms are of little value in differentiating tuberculoma from peripheral neoplasm. The presence of calcification thought to be characteristic of tuberculoma is of little significance as shown by Black and Ackerman. They were able to demonstrate the presence of calcium in twelve cases microscopically, but in only two by x-ray film. The majority of cases also lack other roentgenological evidence of tuberculosis. Generally, tuberculoma appears as a round, demarcated, homogeneous density. A few show cavitation or calcification.

The differential diagnosis of these solitary lesions should include primary neoplasm, metastatic tumors, encapsulated effusions, cysts, abscesses, local pneumoni-

	Cases	Malignant	Percent Malignant
Thornton Adams Block	23	17	73%
Davis & Klepser	67	37	55%
Harrington	16	7	43%
O'Brien Tuttle Ferkany	21	9	42%
Abeles Ehrlich	21	8	38%
Hood Good Clagett McDonald	156	55	35%
Fink	30	10	33%
Sharp Kinsella	55	15	27%
Husfeldt Clarlsen	33	7	21%
Storey Grant Rothmann	40	7	17%
Effler Blades Marks	24	4	16%
Mahon Forsee	55	4	7%
	541	180	33%

tis, benign tumors, granuloma and tuberculoma.

Case Reports

I. O. F., a 39 year old white female, was first seen in May, 1953, complaining of pain in her left chest and a cough productive of white, mucoid sputum. Four years ago she had an episode of hemoptysis. A recent x-ray of the chest by the mobile unit showed a lesion in the right chest and she was advised to have a general examination. An x-ray showed a solitary lesion in the right upper lobe measuring 2 cm in diameter. Physical examination and laboratory studies were normal. Bronchoscopic examination was negative. During a right thoracotomy a circumscribed mass was found in the posterior segment of the upper lobe and was excised as a wedge resection.

PATHOLOGY REPORT: There is a 3 cm wedge of lung containing a 2 cm sharply circumscribed firm gray mass with concentric laminations. Microscopically the nodule consists of collagenous connective tissue with areas of necrosis and calcification. Around the periphery is a collection of pigmented phagocytes and scattered lymphocytes, but no evidence of active disease in the peripheral portion. Impression: inactive tuberculoma.

II. R. O., a 30 year old white male was first seen in February, 1953. Since 1949 he had serial chest films which showed no change in a small spot on the right lung. first discovered on a routine chest film. He gave a vague history of some pain in the right chest, dyspnea, and a non-productive cough of 3-4 months duration. X-ray of the chest showed a solitary density in the right upper lobe. Physical examination and laboratory studies were negative. A thoracotomy was performed and a 2 cm nodule was found in the superior segment of the lower right lobe.

PATHOLOGY REPORT: There is a section of lung containing a 15 mm firm caseous-like nodule with a fibrous capsule surrounding necrotic material which is mostly calcified. Microscopic section shows a mild lymphoid infiltration in the adjacent lung tissue. Impression: inactive tuberculoma.

III. T. R., a 46 year old white male who was found to have pulmonary tuberculosis in the right upper lobe on x-ray examination for army induction in 1942. He was hospitalized for 6 months on bed rest and then dismissed as arrested. In June, 1953, on a yearly follow-up film a small circumscribed nodule was found in the right mid lung field. He was asymptomatic and his sputum was negative. Physical examination and laboratory studies were normal. A wedge resection surrounding a 2 cm subpleural nodule in the superior segment of the right lower lobe was performed.

PATHOLOGY REPORT: There is a wedge of lung tissue surrounding an 18 mm subpleural nodule with a firm, thick, fibrous capsule and a calcified laminated caseous center. Peripheral to the nodule are several small partially calcified caseous nodules measuring up to 5 mm in diameter. Microscopic section shows a collagenous connective capsule surrounding a partially calcified caseous center. There is a non specific chronic inflammatory exudate peripheral to the nodule and a few fibro caseous nodules elsewhere. No tubercles are seen. An acid fast stain on the necrotic center was negative. Impression: tuberculoma.

PROGNOSIS: Slow growing neoplasms are the most favorable for resection and cure, therefore the greater need for an early diagnosis. The unchanged appearance of a solitary lesion of the lung by repeated roentgen examination is not conclusive evidence of its benign character. Effler, Blades and Marks consider a tuberculoma as benign if it does not become neoplastic.



Figure 1. Case number 2, Pulmonary Tuberculoma, superior segment, right lower lobe, 7th interspace posteriorly.

They report one of their cases was followed for two years before a positive sputum was obtained. Their mortality rate was less than 1% in resection of these lesions. Greenville-Mathers reported a follow-up on 18 patients with 23 lesions and the following changes: 4 became calcified, 7 showed no change, 5 enlarged, 4 cavitated, 3 cavitated with a spread of the disease, or an incidence of 13%. Spontaneous resolution of these lesions cannot be anticipated. They do not respond to the usual medical treatment of streptomycin and other antibiotics.

THERAPY: Since tuberculomas contain caseous areas and are incompletely hyalinized and calcified, most authors advocate resection of these lesions, because of the potential danger of explosive spread. In most cases it is necessary to resort to thoracotomy and excision of solitary lesions to obtain a pathological diagnosis. Enucleation of the tuberculoma, due to the possible presence of microscopic tubercles in the adjacent parenchyma, is not advisable. The peripheral location of these lesions permit a wedge resection with little danger of a postoperative pleuritis. At the time of thoracotomy, thorough examination of the lung is performed and the definitive procedure is determined by the findings. In 48 operative cases of Mahon and Forsee the following were done: 30 wedge resections, 2 segmental resections, and 16 lobectomies. It is important to preserve as much functional lung tissue as possible. However, it may be necessary to do multiple wedge resections, especially to eliminate all nodules in the upper lobe.

Summary

1. In 541 reported cases of solitary lung lesions, there were 180 malignant lesions, or an incidence of 33%.

2. Thoracotomy is frequently necessary to make a diagnosis in solitary lung lesions.

3. Thoracotomy and wedge resection of tuberculoma can be performed with a mortality of less than 1% which removes a questionable quiescent lesion usually with a patent bronchial connection that may in the future produce a spread of tubercle bacilli.

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The Selection of Patients For Surgery For Mitral Stenosis

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Cutler[1], in 1923, was the first person to use surgical procedures on patients in an effort to reduce or abolish acquired stenosis of the mitral valve caused by rheumatic fever. His approach was through the left ventricle. Souttar[2], in 1924, was the first surgeon to approach the stenotic mitral valve through the left auricular appendage and to employ the so-called finger-fracture method of reducing the stenosis of the mitral valve instead of using cutting instruments.

A total of ten patients with stenosis of the mitral valve were subjected to surgical treatment for the condition up through 1932 and the mortality rate was 80 per cent. In that year, the first era of attempts to correct mitral stenosis by surgical means came to an end because of the high mortality accompanying the procedure.

In 1945, fortified with new information in cardiopulmonary physiology and new procedures in various types of cardiac surgery acquired during the preceding fourteen years and with the knowledge of surgical technique gained during the first era of mitral valve surgery, cardiologists and surgeons were again ready to attack the condition of mitral stenosis by surgery. Thus, in that year, surgical techniques were for the second time instituted for the treatment of mitral stenosis.

For the last five years the accepted procedure has been almost identical to the procedure which Souttar first used in 1924. In this operation, the stenotic mitral valve is approached through the left auricular appendage by a finger or by a finger and valvulotome. The left auricular appendage is sacrificed in the procedure. Harken has been favoring the so-called finger-fracture technique of separating the fusion bridges of the stenotic mitral valve; whereas, Bailey has been using the so-called commissurotomy method, in which a cutting instrument is guided alongside the exploring finger in an effort to relieve by incision the obliterated mitral valve commissures.

Over the past five years more than 1500 patients with mitral stenosis have received either finger-fracture valvuloplasty or commissurotomy for the condition and the combined mortality figure has been approximately 15 per cent. When only those cases that received the procedure within the last two years are considered, the mortality figure has been reduced to about 10 per cent. This reduction in mortality probably represents better selection of cases for surgery and improved surgical technique.

For purposes of this discussion, most of the information which has contributed to the rapid progress in mitral valve surgery can be divided into three main groups. These are: (1) anatomical and physiological research in mitral valve disease, (2) perfection of techniques in surgery and anestheisa on patients with mitral valve disease, and (3) development of better methods and better understanding of criteria for selection of patients for mitral valve surgery. The remainder of this paper will deal with an elaboration on these topics.

Anatomical and Physiological Evaluation in Mitral Valve Disease

Various studies have shown that the degree of narrowing of the mitral orifice varies greatly. In some, there may be only slight narrowing; whereas, in others, the stenosis may be extreme, presenting only a slit-like opening.

Hellems[3], in 1949, described what he termed the pulmonary capillary pressure. He obtained such a pressure by introducing a cardiac catheter into a small pulmonary arteriole after the catheter had been introduced in the routine manner and had passed from the right ventricle into the pulmonary artery. Hellems felt that such a pressure reading was very similar to the pressure reading in the left atrium.

According to Kramer[4], in 1953, when the mitral orifice has a normal area of about 4 sq. cm., blood flow can be maintained at a low head of pressure; and, marked increase in flow is possible with small

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changes in the left atrial pressure. Also, when there is mild mitral stenosis present, when the area of the orifice is about 2.5 sq. cm., the normal resting flow can be maintained at a relatively low pulmonary capillary pressure; but, when there is any increase in the blood flow, as with exercise, there results a marked increase in the pulmonary capillary pressure. If during exercise this required increase in the pulmonary capillary pressure surpasses the osmotic pressure of the plasma, pulmonary edema will result. Furthermore, when mitral stenosis progresses until the area of the orifice is 1.0 sq. cm. or smaller, a so-called critical point is reached regarding the pressure status. When a mitral orifice has been reduced to this size, the left atrial and the pulmonary capillary pressures approach closely to the osmotic pressure of plasma in order to maintain a barely resting blood flow. The maintenance of pressure appreciably above this level for any length of time is followed by pulmonary edema. To avoid this, a compensatory mechanism causes a fall in blood flow. This is brought about by an increase in the pulmonary arteriolar resistance. This process tends to decrease the output of the right ventricle which to some degree protects the pulmonary capillaries from surges of pressure. But, he pointed out that while the increase in pulmonary arteriolar resistance protects the capillaries, it further decreases cardiac output and increases the work load of the right ventricle which eventually leads to its enlargement and failure.

Larrabee[5], in 1949, reported on his pathological studies of lungs in patients with mitral stenosis. According to his series, there was a reduction in the caliber of the intrapulmonary arterioles and small arteries which was brought about mainly by either intimal fibrosis or medial hypertrophy, or both. As these pathological changes progress, the intrapulmonary arteriolar resistance probably increases.

According to Lewis[6], in 1952, the symptom of exertional dyspnea in patients with mitral stenosis was on the basis of pulmonary congestion and decreased cardiac output. He pointed out that as the area of the mitral orifice approaches 1.0 sq. cm., this symptom, as well as paroxysmal nocturnal dyspnea, becomes much more prevalent. Lewis also emphasized that hemoptysis was common when the area of the mitral orifice reached 1.0 sq. cm. or less, which in turn caused an increase in pulmonary capillary pressure. Under these circumstances, the pulmonary arteriolar resistance may not have fully developed; and, a still strong right ventricle may be able to congest acutely the pulmonary vascular bed. Such a process might cause ruptures in dilated channels which serve as collaterals between the high pressure pulmonary veins and the veins in the larger bronchi that eventually empty into the low pressure azygos system. It is thought that the occurrence of hemoptysis may lower pressure in the pulmonary vessel system which accounts for the fact that hemoptysis and pulmonary edema are rarely associated.

Surgical Evaluation in Mitral Valve Disease

It has been learned that mitral insufficiency is a condition requiring the most meticulous evaluation in the selection of cases with mitral stenosis for surgery, and it has been found that the surgeon is in a very important position at the operating table to obtain positive information concerning the degree of mitral insufficiency and mitral stenosis. This information, of course, is important when correlating it with preoperative physiological data and clinical impressions for use in the evaluation and selection of future cases.

Abelmann[7], in 1953, reported the operative surgical impressions on 62 patients who underwent mitral valvuloplasty for mitral stenosis. Immediately after surgery, the surgeon made a drawing of the stenotic mitral valve as the impression was transmitted to him by the sense of touch on his exploring finger. Valve areas were determined from these drawings; and, it was found that these areas showed good correlation with those valve areas that could be measured directly when certain of the cases came to postmortem examination. In this series, definite mitral stenosis was found in all cases. The surgeon also attempted to judge the amount of mitral insufficiency or regurgitation at the time of operation on the basis of the size and force of the regurgitation jet as felt by the exploring finger. When the regurgitant jet was present, it was graded from 1 plus to 4 plus. It was realized, of course, that a regurgitant jet, being a function of the blood pressure and the heart rate prevailing at the time of intracardiac palpation, may have led to underestimation of mitral regurgitation by the surgeon. It was also mentioned that the sensory threshold and experience of the surgeon may vary the judgment concerning the absence or degree of mitral regurgitation. This method of study found mitral stenosis to be ac-

companied by mitral insufficiency of varying degree more often than was clinically suspected.

Clinical Evaluation for Mitral Valvuloplasty

DIAGNOSIS OF MITRAL STENOSIS: Before considering a patient as a possible candidate for mitral valvuloplasty to correct mitral stenosis, it is obvious that the diagnosis of mitral stenosis must be definite. Whether a past history of rheumatic fever or any other etiology can be elicited or not, it has been generally agreed by all who have reported on this problem that a low pitched, rumbling, diastolic murmur heard at the cardiac apex, with or without a presystolic accentuation, means mitral stenosis. This murmur building up into a snapping first sound at the apex of the heart has often been referred to as being characteristic of mitral stenosis. In many cases there can be found an accentuation of the pulmonic second sound which is believed to be caused by the increased pulmonary artery pressure which is a reflection of the elevated left atrial pressure and the pulmonary capillary bed resistance. Insufficiency of the pulmonic valve may also exist which may produce the so-called Graham-Steel murmur. This murmur can easily be confused with the diastolic murmur of aortic insufficiency in some cases. Abelmann[7], in 1953, reported on 62 cases which had the characteristic murmur of mitral stenosis and which had mitral valvuloplasty. All of these cases were found to have varying degrees of mitral stenosis. It has been pointed out in other series of cases, however, that in very tight mitral stenosis the characteristic diastolic murmur may be absent.

Exertional dyspnea has been felt by most reviewers of the subject to be the primary symptom of mitral stenosis; and, they have believed that this symptom is the combined result of pulmonary congestion and a decreased peripheral cardiac output. Lewis[6], in 1952, correlated the symptom of exertional dyspnea with the area of the mitral valve orifice and pulmonary arteriolar resistance; and, although there were exceptions, he found that the patients who had the more severe form of exertional dyspnea also had mitral orifice areas below 1.0 sq. cm. with markedly elevated pulmonary arteriolar pressures.

Paroxysmal nocturnal dyspnea occurred in about 50 per cent of the cases reported by Lewis in 1952. All of these cases had mitral orifice areas of about 1.0 sq. cm. The physiology of pulmonary edema in mitral stenosis has already been discussed. It is believed by some that paroxysmal nocturnal dyspnea is the result, in part, of acute increase in cardiac output brought about by the increased blood volume that is thought to accompany sleep. When this occurs in the presence of a strong right ventricle and a relatively low pulmonary arteriolar resistance the osmotic pressure of the plasma is exceeded and paroxysmal nocturnal dyspnea results.

Hemoptysis developed in about 20 per cent of the cases reported by Lewis. The physiological aspects of this development in mitral stenosis have already been reviewed.

Easy fatigue was elicited as the most prominent complaint in only about 15 per cent of the cases with mitral stenosis in the Lewis series. All of his cases, however, had the symptom of exertional dyspnea ranging from 1 plus to 4 plus. As previously stated, all patients of this group had proved mitral stenosis with average valve orifice areas of less than 1.0 sq. cm.

Palpitation of the heart, symptoms of an embolic episode, or symptoms of coronary artery insufficiency may occasionally be the initial symptom in patients with mitral stenosis. Also, hoarseness or dysphagia caused by pressure of an enlarged left atrium may sometimes be the presenting symptom in this disease.

Besides using the auscultatory findings and the symptomatology in making the diagnosis of mitral stenosis, cardiac fluoroscopy, the electrocardiogram, and cardiac catheterization may be employed to aid in the diagnosis. In the so-called pure mitral stenosis, fluoroscopy of the heart has usually revealed the left ventricle to be of normal size; but, the left atrium generally has been found to be dilated when studied by this technique. Lewis[6], in 1952, reported that all of his cases with mitral stenosis had enlargement of the left atrium. His series showed that about 90 per cent of the left atria were either moderately or markedly enlarged. Pulmonary artery dilatation was found to be a definite aid toward influencing ones opinion as to the presence and degree of mitral stenosis. The Lewis series of cases with proved mitral stenosis showed electrocardiographic changes indicative of right ventricular hypertrophy in 60 per cent. A lower percentage revealed electrocardiographic changes of right bundle branch block; and, in some, both right ventricular hypertrophy and right bundle branch block were found in combinations. It is believed that

the pulmonary arteriolar resistance as well as the mitral stenosis affects the electrocardiographic pattern.

Cardiac catheterization of the pulmonary arteriolar bed revealed elevated pressures in most cases in all series of cases with mitral stenosis. In general, it was found that usually the patients with the more advanced mitral stenosis produced the highest pulmonary arteriolar pressures.

Consideration of Cardiopulmonary Functional Capacity: In the process of selection of patients for mitral valve surgery, Harken[8], in 1952, reviewed his criteria for the consideration of surgery on patients with mitral stenosis based on the cardiopulmonary functional capacity. In his classification there were 4 groups of patients:

Group I comprised those patients in whom the course of the disease was found to be benign. In these patients, the auscultatory findings of mitral stenosis were present but symptoms were absent. He felt that surgery was definitely not indicated in this group because some of the patients will never progress to the point that they will need surgery. But, this group should be followed carefully so that in the event surgery becomes indicated, it can be performed before the disease has progressed to a higher risk group.

Group II comprised those cases that were statically handicapped by a mild or moderate degree of exertional dyspnea. Those cases which developed rare attacks of pulmonary edema and other pulmonary symptoms brought about by unusual exertion were included. This was considered a borderline group because the symptoms were nonprogressive. If there were no absolute or relative contraindications to mitral valve surgery, these patients were selected for surgery on the basis of discomfort and limitation in the individual cases. The mortality rate in such cases was less than 5 per cent. Surgery should be delayed in these patients who can tolerate their symptoms and agree to do so, because better valvuloplasty within the next few years may reduce the mortality rate even further.

Group III comprised those cases with mitral stenosis with symptoms which were progressive rather than static. In this group, progression in the severity of exertional dyspnea was noted over a period of time. Attacks of pulmonary edema and attacks of hemoptysis were prominent features. When no absolute or relative contraindications to surgery existed, surgery was felt to be definitely indicated. Harken stated that life expectancy under medical therapy in this group was hazardous; whereas, considerable benefit could be gained from valvuloplasty with a mortality rate of less than 10 per cent. In general, irreversible damage to the myocardium, lung, and liver has not occurred in this group, therefore, these patients constitute the ideal and urgent candidates for mitral valvuloplasty.

Group IV comprised those cases with mitral stenosis in whom the disease had progressed until the patients were completely incapacitated. The pulmonary disability may not be greater than in those cases of Group III; but, there was usually right ventricular failure manifested by chronically elevated venous pressure and enlargement of the liver. These patients may have edema and decreased peripheral blood flow. Many had had embolic episodes and most had auricular fibrillation. When absolute or relative contraindications to surgery did not exist, Harken stated that these patients should have valvuloplasty. The mortality rate was 90 per cent in one year in a similar group of cases selected for valvuloplasty who refused the procedure. Although improvement in this group, when it occurred, was less dramatic, no patient who survived the surgery was made worse.

Consideration of Age: The age of patients should always be considered when selecting patients for surgery for mitral stenosis. It has been reported that it requires from one to 20 years for mitral stenosis to develop to a degree for it to cause symptoms. Since the largest incidence of rheumatic fever has been reported between the ages of 5 and 15 years, there have been very few reports in the literature of valvuloplasty for mitral stenosis on patients below the age of 20. It should be understood, however, that the minimal age limit for mitral valve surgery is a relative thing which depends upon when a particular patient developed the initial rheumatic fever attack and how rapidly the mitral stenosis progressed. Janton[9], in 1953, reported on the use of mitral commissurotomy on twenty patients with mitral stenosis whose ages ranged from 50 to 61 years. The mortality rate was 10 per cent, but seventy-five per cent of the cases obtained moderate to excellent improvement.

Consideration of Auricular Fibrillation: It has been the general belief that auricular fibrillation does not constitute

a contraindication to mitral valvuloplasty as long as the ventricular rate can be well controlled. However, the presence of auricular fibrillation increases the possibility of embolization during surgery.

CONSIDERATION OF PREVIOUS EMBOLIC EPISODES: If no absolute or relative contraindications for mitral valve surgery exist in a patient with mitral stenosis, the occurrence of repeated embolic episodes in the greater circulation may be considered an indication for mitral valve surgery. Since the procedure entails ligation and amputation of the auricular appendage, a favorite site of thrombus formation can be eliminated. Also, enlargement of the mitral orifice reduces the factor of stasis in the atrium which reduces the tendency to recurrent thrombus formation. Janton[10], in 1952, reported 22 cases which had had cerebral, visceral, or peripheral emboli before mitral valve surgery was performed. Some of these cases have been followed for 3 years after surgery, and he reported that there had been no recurrent embolic episodes in any of the cases.

CONSIDERATION OF CALCIFICATION OF THE MITRAL VALVE: Calcification of the mitral valve has not been considered a contraindication to mitral surgery but, in such cases, satisfactory valvuloplasty has not always proved possible because of the calcification. The possibility of producing an embolic episode from a dislodged calcific plaque has been mentioned as being present under such circumstances.

CONSIDERATION OF ABSOLUTE CONTRAINDICATIONS TO SURGERY: Before the final selection of a patient with mitral stenosis for valvuloplasty can be made, certain absolute and relative contraindications to surgery must be meticulously evaluated by the internist or cardiologist. Active rheumatic carditis and subacute bacterial endocarditis have been considered absolute contraindications to mitral valve surgery by most everyone who has had the responsibility of selecting cases. Perhaps the main reason for this has been that the presence of such active disease may account for the progressive pattern of disability in an individual case rather than the mechanical burden of the narrowed mitral valve. Extreme enlargement of all cardiac chambers offers an absolute contraindication to surgery. Also, a recent coronary occlusion with myocardial infarction has been considered an absolute contraindication to mitral valve surgery. In addition to this, when myocardial insufficiency can not be influenced by bed rest and the most intensive medical therapy, surgery for mitral stenosis should not be attempted.

CONSIDERATION OF RELATIVE CONTRAINDICATIONS TO SURGERY: Other cardiac valvular diseases have been considered to be relative contraindications to surgery for mitral stenosis depending on the valve involved and the degree of involvement.

Mitral insufficiency has been considered to be one of the most important lesions to be evaluated. According to Abelmann[7], in 1953, an apical systolic murmur of grade 3 intensity or louder in a patient with mitral stenosis should suggest mitral regurgitation. However, this finding has not allowed an accurate estimate of the severity of the mitral regurgitation and it therefore, has been of limited value in assessment of a patient for mitral valvuloplasty. In the absence of an apical systolic murmur mitral regurgitation is unlikely or not severe. In the Abelmann series of cases it was found that mitral insufficiency was present at operation more often than was clinically suspected. It was also pointed out that marked mitral regurgitation may exist with only a faint apical systolic murmur; and, conversely, a loud apical systolic murmur may exist with a mitral insufficiency associated with a tight mitral stenosis.

Gorlin[11], in 1952, reported that all of 11 patients with mitral stenosis and mitral insufficiency had easy fatigue as the major symptom while dyspnea was not a prominent symptom. However, Lewis[6], in 1952, stated that easy fatigue was the prominent symptom in about 15 per cent of his cases of mitral stenosis without mitral insufficiency. Abelmann[7], in 1953, concluded from his studies of mitral stenosis coexisting with mitral insufficiency that when fatigue overshadows dyspnea one is justified in postulating the presence of mitral insufficiency but, he felt that on the basis of this criterion alone one should not conclude that regurgitation is the predominating mitral lesion and that valvuloplasty is contraindicated.

Cardiac chamber analysis with fluoroscopy showing left ventricular enlargement in mitral valve disease in the absence of myocardial failure, hypertension, or aortic valvular disease indicates mitral insufficiency. This has been thought to be caused by the attempt of the left ventricle to maintain an adequate aortic output despite mitral regurgitation.

Abelmann stated that systolic expansion of the left atrium as observed by fluoroscopy should suggest mitral regurgi-

tation, but, he felt that it does not justify a conclusion as to the degree. He further stated that the absence of this sign does not rule out marked mitral regurgitation.

Gorlin[11], in 1952, pointed out that the absence of electrocardiographic evidence of right ventricular hypertrophy in patients with mitral valve disease suggested the presence of both mitral stenosis and mitral insufficiency. Abelmann[7], in 1953, reported on the electrocardiographic findings while attempting to evaluate mitral insufficiency and he concluded that electrocardiographic evidence of right ventricular hypertrophy frequently occurred in pure mitral stenosis, but that it also may be associated with severe mitral insufficiency.

Biorck[12], in 1953, stated that he feels angiocardiography is of value in all problematic cases of mitral valve disease in helping to obtain information concerning the exact size of the left atrium and left ventricle as well as the degree of mitral regurgitation. He felt that increasing experience would make this a valuable diagnostic procedure in questionable cases.

Cardiac catheterization has added much knowledge concerning the hemodynamics in mitral stenosis, but, it has not aided greatly in the evaluation of mitral insufficiency.

The phonocardiogram, auricular esophagograms, electrokymograms and ballistocardiograms have been of little assistance in the evaluation of patients for mitral valvuloplasty.

Moderate to marked degrees of mitral insufficiency have been generally considered an absolute contraindication to mitral valvuloplasty, whereas minimal degrees of mitral insufficiency have not been considered a contraindication, provided the degree of mitral stenosis is relatively greater.

In the selection of cases for mitral valvuloplasty that have mitral insufficiency associated with their mitral stenosis, a combination of the above discussed criteria should be evaluated from the standpoint of mitral insufficiency before the final decision should be made. Abelmann[7], in 1953, showed that when evaluating mitral insufficiency by a combination of a grade 3 or 4 apical systolic murmur, by evidence of marked left atrial enlargement, by systolic expansion of the left atrium as seen on fluoroscopy, and by left ventricular enlargement, he was able to produce the smallest number of false negative and false positive diagnoses of mitral insufficiency as verified at surgery.

Aortic stenosis, according to Kramer[4], in 1953, which is severe enough to cause left ventricular hypertrophy presented an absolute contra-indication to the correction of mitral stenosis. Aortic stenosis must be very minimal before surgery for mitral stenosis should be done, because the aortic stenosis would tend to make worse any mitral insufficiency which might be created by surgery.

Aortic insufficiency also presents an absolute contra-indication to mitral valvuloplasty if it has produced any appreciable degree of left ventricular enlargement. It has been generally felt that if aortic insufficiency is not severe enough to produce peripheral signs and symptoms and if the diastolic blood pressure is not below 50 mm. of Hg., then the aortic insufficiency is not severe enough to contraindicate mitral valve surgery.

Summary and Conclusions

1. A brief review of the anatomical and physiological interpretations in mitral valvular disease was presented and the diagnostic criteria for mitral stenosis were discussed.

2. The clinical evaluation of patients with mitral stenosis was discussed, with special consideration of the indications and contraindications for surgery.

3. The selection of patients for surgical correction of mitral stenosis requires precise evaluation of a combination of factors. These factors include an accurate appraisal of the cardiopulmonary functional capacity as well as certain relative and absolute contraindications to surgery.

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Infant Feeding in the Prevention and Treatment of Disease*

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Every day in the practice of medicine we utilize knowledge gained by painstaking study in the field of nutrition. Like many every day things, these facts are accepted as common knowledge and we do not emphasize them enough. This is true in infant feeding where hurriedly given, and improperly followed instructions may deprive an infant of his right to grow and develop and be free from many diseases or infirmities.

New fads and new trends are with us always and it is hard to sensibly evaluate new ideas. Yet, it is our duty to pick out all which can aid us in practice. Brenneman once commented that "the field of infant nutrition has gone from a chaos of complexity to a chaos of simplicity." The simplified rules of nutrition are to be desired, but we must still keep in mind the reasons behind our advice and our aims in recommending certain feedings.

What practical information can we gain from the numerous reports or theories, experiments and experience in infant nutrition? How can we give our small patients the benefit of the advanced knowledge? We must accept a few proved principles and take time to explain them to our patients. In choosing methods we must have the following aims and beliefs.

1. We must realize that proper food has much to do with maintaining or regaining health. Therefore, we should take time to give definite directions to the infant's parents.

1. This advice must be understandable and not require undue expense or labor.

2. We must believe that it is our duty to prevent vitamin deficiency and anemia due to improper diet, and that we must guard our patients against diseases caused by an excess of vitamins or foodstuffs.

3. We must treat food intolerances, or better, prevent them by early recognition of allergies or congenital defects in digestion.

4. We must prevent diseases caused by uncleanliness.

5. We must be able to suggest proper and sensible feeding during illness.

6. We must instruct parents in proper feeding technique so that good feeding habits are developed early. By this we can prevent many of the feeding problems of later life.

7. We must protect ourselves and our patients against harmful or senseless fads.

Vitamin Deficiencies

There is a staggering amount of knowledge accumulated regarding the chemical composition, source, and need for the various vitamins isolated. There are fairly clear cut symptoms of diseases due to an insufficiency as well as an excess of many of the individual vitamins. Here again we must find our way between the chaos of complexity and chaos of simplicity. One good rule to follow is Better Food Selection, rather than vitamin dosing.

Practical food processors have done much to help us combat deficiencies. Vitamin D milk, fresh or evaporated, as well as special formulas with added vitamin D are helping reduce the incidence of rickets.

Improved canning and freezing methods employed in processing fruits and vegetables have helped prevent scurvy by retaining some of the vitamin C.

More vitamin B is available through enriched flours and cereals, meat products acceptable to infants, and increased knowledge regarding the preserving and preparing of vegetables and meat.

We should encourage and support all agencies designed to teach the better methods in choosing and preparing foods. Home economic classes in schools, 4-H classes, and cooking schools sponsored by various organizations should not only stress the

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preservation of vitamins, minerals and taste, but also stress the use of economical foods. Some of the prepared foods that we consider necessities for proper infant nutrition may still be in a luxury class to some of our patients. The above mentioned instruction would be appreciated by them.

Vitamin A deficiency is rare, as the vitamin A content of breast or unskimmed cow's milk usually supplies the required 1500 international units per day. If a low fat milk is fed, or if there is steatorrhea, a deficiency may develop and additional A should be supplied. Symptoms of overdosing do occur. Caffey[1] has reported bone changes resembling those seen in cortical hyperostosis.

Vitamin D deficiency is also becoming rare, but rickets still occurs. 400 to 800 or more international units of vitamin D is needed daily, at least during the first two years of life. If fat absorption is poor, as in celiac disease, the intake of vitamin D should obviously be increased. Most evaporated milks and special formulae are fortified and many dairies have vitamin D fortified products. It is still considered good practice to protect the infant by giving codliver oil or vitamin D in some other form.

Overdosage of vitamin D may develop calcification in the kidney, blood vessels or heart, diarrhea and weight loss. A daily intake of 150,000 units per day for several weeks is usually necessary to cause these symptoms.

Symptoms of vitamin B deficiency are rare when the milk intake is adequate. The present practice of starting cereals and meats early and the use of enriched flour precludes deficiency symptoms in most infants. Autoclaving milk destroys some of the vitamin B. This is usually made up by vitamin B from other foods. Only laboratory induced toxicity from overdoses of vitamin B have been reported, so there is probably no harm in adding concentrated vitamins to the diet. The status of B-12 requirements in human infants is still not completely settled.

Vitamin C deficiency still occurs. Since vitamin C is easily oxidized and the oxidized form is heat labile, much is destroyed in cooking vegetables or processing milk. Orange juice and tomato juice are good sources of vitamin C, but both may act as allergens in the potentially allergic child. Crystalline preparations of vitamin C are non-allergic and are relatively inexpensive—30 to 100 mgs. per day are recommended. Prematures require more vitamin C than a full term infant. Overdosage of vitamin C produces no known toxicity.

The trend towards early feeding of solids, including egg yolk and meat will help combat the anemia so common after three months of age. This is an important step forward and it is preferable to supply the iron needed by these means rather than by prescription. (Yet the early introduction of various foods may produce sensitivities and food allergies.)

Diarrhea

It is hard to discuss any illness in infancy without bringing in diarrhea, as gastrointestinal upsets so often accompany any disease. Proper feeding has so much to do with the prevention or treatment of diarrhea that it cannot be left out of this discussion. Frequent loose stools, regardless of cause, can soon deplete the infant's body of fluids. The vomiting and diarrhea carries off electrolytes and a chemical imbalance soon results. There we have a major problem on our hands attempting to combat dehydration, acidosis and imbalance of the various ions.

It is a therapeutic triumph to overcome this condition but it is not always accomplished. If judicious handling early in the disease can prevent this, a great service has been rendered.

I shall try to outline and review the basic principles involved.

Uncleanliness in the home, in the preparation and storage of formula and food still account for much diarrhea in this enlightened world. We cannot expect many of our patients to know aseptic technique. Time spent in carefully explaining proper sterilization of the formula will prevent many cases of diarrhea.

The present trend towards the early use of homogenized milk, often unmodified has many supporters and seems a perfectly acceptable feeding in many cases. Many of the most enlightened parents look upon homogenized milk as sterile, forgetting that this excellent culture medium can be contaminated in many ways after leaving the dairy, hence it is well to recommend that bottled milk from all dairies be boiled before giving it to small infants.

Evaporated milks or special formula preparations have the advantage in that only the diluting water and bottles and nipples need be boiled.

One simplification of formula preparation heartily endorsed by some parents and certainly of great value when the

source of milk (e.g. family cow) or refrigeration facilities may be questioned, is terminal sterilization.

It can be accomplished with a minimum of equipment and guarantees sterile formula and bottles which are relatively safe for a day even if stored under primitive refrigeration.

Diarrhea may be caused by either overfeeding or underfeeding. Therefore we can prevent trouble by a more careful supervision of the infant's diet. In her zeal to produce a fat, healthy baby, many mothers will give more food than can be tolerated. On the other side, the very conscientious parent may follow formula instructions given three months ago and unwittingly produce a starvation diarrhea in her infant.

Poorly tolerated foods to which there may be a definite allergy may cause vomiting or diarrhea and produce a serious chemical imbalance if the cause is not recognized. Allergy will be discussed later in this paper.

Unwise and unwarranted dosing with laxatives by a constipated mother or a bowel conscious grandmother may be the cause of an intestinal upset in the innocent infant. More time should be taken to explain the variations acceptable in type and number of infant stools. A change in diet, prune juice or modified formula should be used before any drugs.

Parenteral infections often cause a diarrhea and this symptom should be anticipated if not present. Early treatment of the otitis media, pyelitis, pneumonia or whatever the case may be will often control the diarrhea. However, dehydration and a chemical imbalance may develop which is reversible only under intensive parenteral fluid therapy, so that preventive methods are always indicated.

The nondescript epidemics of vomiting and diarrhea, sometimes associated with fever, sometimes with a pharyngitis, or other symptoms seem to be with us with annoying regularity. Whether classified as "flu," "the virus," or more accurate or less accurate names, they usually respond best to aspirin and good nursing care. Here again we should have a definite plan in the management of the case. Maintaining a proper fluid and nutritional balance is of greatest importance.

Treatment of Diarrhea

The general principles in attempting to prevent dehydration, acidosis and get the diarrhea and vomiting under control are very simple.

First, an adequate fluid intake must be insured. Fluids vomited less readily seem to be clear liquids given frequently in small quantities. Even for very young infants, carbonated beverages do very well and gingerale and the cola drinks (unless there is allergy to chocolate) are well tolerated. Their taste makes them acceptable, they contain readily assimilated carbohydrates, and it has been suggested that cola drinks may have some specific action. Barley water or rice water will be taken when plain water is refused and should not be forgotten. In reality, we are practicing the early starvation procedure, but still supplying fluids.

When vomiting has ceased, some of the better tolerated foods may be introduced carefully. Unsweetened apple sauce or the scraped apples of our grandmother are taken well. Ripe bananas, gelatins, rice cereal and often strained meats are tolerated early. Too great zeal in attempting to get the convalescent infant back to previous weight may end in disaster. Sugars, which were once condemned, seem to be fairly well tolerated. In fact, glucose water or waters fortified with some dextrin-maltose preparation may be given early. At least at present, fats are considered improper by most so that a low fat milk should be used when returning to milk feeding. Skimmed boiled milk or butter milk should be used.

Drugs for specific infections are certainly indicated, but in so many cases of the diarrheas mentioned, they do not seem to alter the course, so we should think first of the dietary approach.

Some of the feeding problems formerly treated by clumsy trial and error methods may now be approached surely and scientifically because of a change in ideas as to basic pathology. I would like to mention celiac disease as an example. The classical picture of the one or two year old with distended abdomen, wasting of the buttocks and bulky, greasy, foul smelling stools is still rather rare.

Dorothy Anderson[2] has found evidence of symptoms beginning at birth and also a family history of gastrointestinal disturbances which did not reach the severity of the classical picture. It is quite likely that milder degrees of this syndrome may be encountered rather frequently in any practice. While we once thought of it as a disease of fat intolerance, C. M. Anderson[3], Sheldon and Lawson[4] of Eng-

land, and many others have pointed out that there may be poor fat absorption due to associated starch intolerance. They have gone farther and incriminated the glutens in wheat and rye as substances not tolerated. Hence the present approach is that of a diet free of the glutens in wheat and rye, yet a normal fat intake. The reasoning is relatively new, yet as early as 1921, this type of diet was believed to be beneficial.

How does the advancement in knowledge of such an isolated syndrome affect us in practice? First, by recognizing a definite food intolerance such as wheat or rye in an early celiac, we can maintain nutrition and vitamin absorption and keep up a more normal rate of growth.

Secondly, the awareness of the possibility of certain food intolerances causing serious malnutrition will teach us to follow the infant's diet more carefully. If we accept the precepts that there may be varying degrees of this metabolic defect when such patients do appear, we can, with the help of a good history and a knowledge of the possibilities, intelligently make a tentative diagnosis without all the laboratory aids. More important, we can give feeding advice which will protect the infant from more serious symptoms and perhaps overcome those he has.

Food Allergy

When food intolerance is mentioned, we usually think immediately of an allergy. This much abused diagnosis is too frequently misapplied in infancy. It is true that food to which the infant is allergic can cause fretfulness, vomiting, diarrhea, rhinitis, eczema or other rashes and a host of other symptoms. So can improper handling, poor home conditions, lack of cleanliness, neglect, or too much misdirected attention.

A sensible approach must be developed. The unhappy infant allergic to cow's milk may become malnourished, a victim of diarrhea and deprived of his right to grow and develop normally. Jerome Glaser[5] has made workable suggestions in managing the allergic or potentially allergic infant and I will quote freely from his work. The present trend towards early feeding of solids subjects the immature intestinal tract to potential sensitizing agents.

Certain foods can cause allergic manifestations in young infants, yet be introduced later and be well tolerated. Glaser[6] among others reasoned that there may be absorption of improperly broken down proteins in the immature intestinal tract. These substances were thought capable of sensitizing the individual. The logical move would be to remove such substances from the diet until the infant's intestines were no longer permeable to unchanged proteins. By shielding the potentially allergic infant from the insult of allergens early, we may prevent many of the immediate or later developing allergic manifestations.

In 1949 Glaser[5] outlined a simple program to prevent allergy. Since allergic manifestations are quite common and since they often crop up when there is no proved or known family history of allergies, we should start all new foods with the thought of them being potentially allergenic. It requires less effort than one would think.

Breast milk can be taken by most allergic children, so special efforts should be executed to get the mother to nurse her baby.

If breast feeding is impossible, the potentially allergic child should have a carefully chosen formula. Since dairy products are a big part of our diet throughout life, it has been suggested that soybean[7] or meat base[8] formula be started immediately so that the potentially allergic child could not be sensitized during early life. Later his intestinal tract becomes more mature and he might handle cow's milk. Many of us would find this impractical as a general rule—but if the family history shows up numerous allergies, we might be wise in adopting it even if it puts considerable hardship on the family.

The alternative is to be sure that a heat processed cow's milk be given. Evaporated milk or some of the prepared formulae should be tried. If no reaction occurs they can be continued. If there is evidence of intolerance to cow's milk formula on an allergic basis, it is foolish to experiment with modifying the formula. The immediate withdrawal of cow's milk and the temporary substitution of a soy bean product is the wisest move. A few months later, cow's milk may cause no reaction.

There are other foods that frequently cause allergies. Orange juice, eggs, wheat and chocolates are some of the common ones. These should be withheld from the diet. Ascorbic acid may be given in place of orange juice until the age of six months. Egg yolk may be withheld until nine months. This excellent source of iron may be replaced by the better tolerated meats.

Wheat, which plays such an important part in our diet, should be withheld and other cereals given during the first few months. Chocolate can be withheld for at least two years.

As to the introduction of the various cereals, fruits, and vegetables, we can find which cause a reaction if only one pure food is introduced at a time. For example, if carrots are given for a few days and there is no evidence of colic, rash, or diarrhea, we may assume they are tolerated and then alternate them with peas. The parent can then spot the offending food and withhold it. It is true mistakes may be made and an innocent food incriminated, but there will still be a wide choice and the infant's nutrition will not suffer.

Summary

1. Feeding instructions must be given carefully if we wish to prevent disease caused by vitamin deficiency or an excessive intake. Anemia may also be prevented by proper feeding.

2. Improper foods or improper food preparation can cause diarrhea. Intelligent feeding instructions are often more important than drugs in controlling vomiting and diarrhea in infancy.

3. Recent developments in the treatment of celiac disease were discussed. The possibility of milder degrees of this condition was mentioned.

4. "Preventive allergy," or procedures recommended in protecting the infant from foods which may, or which do, cause symptoms of allergy were outlined.

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Anesthesia for Wounded Men*

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Careful preparation of wounded men for surgical intervention can be nullified by the incorrect choice of anesthesia. In periods of disaster it can confidently be expected that shortage of skilled anesthetists will be the rule. However capable the anesthetists may be, it has been shown by experience that the following practices will give the best results in the hands of the experienced man as well as the novice.

PREANESTHETIC MEDICATION. Two drugs, atropine and pentobarbital sodium, are of real importance in preanesthetic medication. (a) Atropine 1/100 grain, 0.6 mg., may be given by subcutaneous injection about one hour before anesthesia is to be induced. The same dose can be given intravenously shortly before anesthesia if time has not permitted earlier subcutaneous injection. (b) Pentobarbital sodium 1½ grains, 90 mg., may be given by mouth one hour before surgery or intravenously if operation is urgent. The use of morphine or other narcotic in the preanesthetic medication is not necessary (unless pain is present) and is actually undesirable in wounded men.

INHALATION ANESTHESIA. The stomach must be emptied before general anesthesia is started. This is accomplished by insertion of a gastric tube, which is done in such a way that vomiting is induced. The stomach cannot be dependably emptied by any means short of vomiting. Food eaten many hours, even eighteen hours, previously will still be retained in the stomach if wounding occurred before the stomach had emptied. Aspiration of vomitus is the commonest serious, often fatal, needless accident occurring in hospital installations. It is seldom excusable.

Nitrous oxide provides useful anesthesia for minor procedures (simple super-

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ficial debridement of wounds, painful changes of dressings), as a supplement to other forms of anesthesia, and for induction of ether anesthesia. It is always used with at least 80 volumes per cent of oxygen. The induction of ether anesthesia with ether itself is particularly easy in the seriously wounded. Ether is the choice in the seriously wounded, particularly for major thoracic surgery (through the open pleura), abdominal surgery and in caring for compound fractures of the femur. It is the choice when patients are in shock, when shock is feared, or whenever the circulatory system may be impaired and general anesthesia is required. Ether is so widely recognized as the most desirable agent for use in the seriously wounded that its merit is also evident for patients who are in less precarious condition. It has been used too little. Ether is highly inflammable and explosive. In hot climates keep ether cans on ice or in wet bags exposed to a breeze if no ice is available, just before use.

Ether anesthesia is generally best administered through an endotracheal tube. Size 32 French is satisfactory in most adult patients. Sizes larger than 34 French are not necessary. A soft wire (copper) introducer will greatly facilitate the insertion of an endotracheal tube.

Local Anesthesia. Local anesthesia is accomplished chiefly with procaine hydrochloride (tetracaine or cocaine for topical anesthesia) for neurosurgical, for some maxillofacial and for minor surgical procedures. In great disasters when many casualties are awaiting treatment, regional block procedures are of little value, chiefly because of the skill and time that they require and the frequent multiplicity of wounds. Chief exceptions here are paravertebral or intercostal blocks for controlling thoracic pain and sympathetic blocks when the circulation of an extremity is impaired.

Epinephrine in 1:200,000 dilution will greatly prolong (triple or quadruple) the action of local anesthetic agents. Use 0.5 cc. of a 1:1,000 solution of epinephrine to 100 cc. of 1 per cent procaine hydrochloride. However, epinephrine or other vasoconstrictor agent is not to be used with local anesthetic agents in surgery of the fingers, toes, ears, nose, penis or scrotum. Sloughs may be caused if this is done. Epinephrine is not to be added to local anesthetics if their action is to be supplemented with cyclopropane, chloroform or ethyl chloride.

Sensitive persons or patients who have received an overdose of a local anesthetic agent will often have convulsions. Specific treatment is afforded by soluble barbiturates, for example, pentobarbital sodium or thiopental (pentothal) sodium. Usually 2 to 4 grains (120 to 240 mg.) will be sufficient. The intravenous route of administration is used.

Reasonable doses of procaine hydrochloride will not exceed either 200 cc. of 0.5 per cent, 100 cc. of 1.0 per cent or 40 cc. of 2.0 per cent solutions. These maximum total doses should not be administered in less than an hour to healthy adults in good condition. Local anesthetic agents will be used with great caution and in small dose in patients with liver disease. They will be avoided in patients having a history of sensitivity to them. Inquiry is always to be made concerning this.

Spinal Anesthesia. Spinal anesthesia is never acceptable for persons recently and seriously wounded. Such tolerate it poorly.

Intravenously Given Thiopental (Pentothal(R)) Sodium. The simplicity with which thiopental (Pentothal(R)) sodium anesthesia can be made available, particularly the compactness and the simplicity of the necessary equipment, the ease with which a smooth induction can be produced even by the inexperienced, the usual prompt awakening of the patient, the number of cases an inexperienced man can "get away with" even though his actual death rate may be unreasonably high in comparison with what it should be—all these factors have tended to outweigh the fact that thiopental is a powerful tool, that overdosage is not always easy to overcome, that use of the drug is incompatible with certain types of injury and that its fatal dose varies extremely widely from one patient to another.

Anyone employing thiopental (Pentothal (R)) sodium should, for safety, be aware that among other effects the drug (as do all barbiturates) impairs the sensitivity of the respiratory center to its normal chief stimulus, carbon dioxide. Under full thiopental anesthesia the body has to make use of a supplementary mechanism in order to keep respiration going. To maintain respiration a shift is made from the normal driving action of carbon dioxide on the respiratory center

to the action of anoxia on the carotid mechanisms in the neck. Anoxia will stimulate respiration just as powerfully in the patient under deep thiopental anesthesia as under light anesthesia.* Thus the uninformed anesthetist may believe that respiratory stimulation means that the patient under thiopental anesthesia is awakening, whereas it may mean simply that the patient is not getting enough oxygen. A wrong interpretation here, leading to the further administration of thiopental (Pentotha(R)) sodium, has caused deaths. In other words, the true depth of thiopental anesthesia may be impossible to determine when there is a low oxygen content of the blood. For safety, certainly always in long operations, oxygen is administered with thiopental. As explained above, the respiratory center of the patient under full thiopental anesthesia loses its sensitivity to carbon dioxide. In fact, carbon dioxide becomes a depressant to respiration under this agent, and use of carbon dioxide as a respiratory "stimulant" is contraindicated during treatment of respiratory depression caused by thiopental or any other barbiturate. Acceptable practice with thiopental (Pentothal(R)) sodium involves the use of a 2.5 per cent solution, routine administration of oxygen to the patient in all except short (half-hour) operations, and frequent observation of pulse and blood pressure during anesthesia.

For preanesthetic medication before thiopental administration, morphine may or may not be used. It is possible, but not certain, that preliminary morphine lessens the total quantity of thiopental needed. Whether or not too high a price may be paid for this advantage is not certain at this time. Of considerably more importance is the use of atropine. Its purpose is to minimize undesirable vagus reflexes. Atropine 1/100 grain (0.6 mg.) should be given subcutaneously about one hour preceding anesthesia, with half the dose (1/200 grain, 0.3 mg.) given intravenously just before anesthesia is started. During periods of disaster, in times of heavy admission of patients, there will not be time for the above and it will be satisfactory to give atropine 1/100 (0.6 mg.) intravenously 10 or 15 minutes preceding anesthesia. (In the presence of severe tachycardia use of atropine is avoided.) When troublesome laryngeal spasm occurs during thiopental anesthesia, administer atropine 1/100 grain (0.6 mg.) intravenously as soon as possible, even though the same dose was administered in preanesthetic medication shortly before.

CLINICAL CHOICE OF THIOPENTAL (PENTOTHAL (R)) SODIUM. Thiopental is of proved great value; that is certain. Equally certain it is that the choice of thiopental is contraindicated in the seriously wounded. Its use is unwise in the presence of certain injuries:

(a) When the patient is suffering from morphine overdosage.

(b) When shock is present, or when shock is anticipated. The following wounds and conditions are likely to be associated with shock: penetrating wounds of the chest or of the abdomen, compound fractures of the long bones and severe hemorrhage, even when it comes from otherwise trivial wounds. Thiopental (Pentothal(R)) sodium should never be used in the above conditions; ether is far safer, when general anesthesia must be used.

(c) When incision of a cervical abscess is to be undertaken, the use of thiopental is unwise. Deaths have occurred in such circumstances. Apparently, inflammation in the region of the carotid bodies and sinuses causes sensitization of reflexes arising there. These probably account for the notorious incidence of sudden death during such operations. Since thiopental (Pentothal(R)) sodium (and other barbiturates) is not especially effective in depressing these reflexes, its choice should be avoided in most cases of this kind. Rarely, as in some cases where compound fractures of the face may also be present, thiopental may be the reasonable choice for handling cervical abscesses. In such cases the following precautions should be observed: use heavy atropinization in the preanesthetic medication. Do not begin surgical intervention in patients with irritable carotid sinus until at least ten minutes after induction of thiopental anesthesia. Avoid pressure on the carotids. If feasible, block them with local anesthesia.

In another group of patients the use of thiopental (Pentothal(R)) sodium may at times be debatable but is usually unwise:

(a) In general, thiopental administra-

(Continued on page 716)

*Beecher, H. K., and Moyer, C. A.: Mechanism of Respiratory Failure under Barbiturate Anesthesia (Evipal, Pentothal). J. Clin., Investigation 20: 549-566, 1941.

CASE DISCUSSIONS

FROM THE LOUISVILLE GENERAL HOSPITAL

Chronic Lung Disease and Its Complications

Presentation of the Case:

A. I. Urgancioglu, M.D., and

Grover B. Sanders, M.D.

Present Illness

H. B., a 61 year old w/m was admitted to L.G.H. 6-22-54 complaining of shortness of breath, hemoptysis and generalized weakness. His shortness of breath which had been present since 1949 was without seasonal variation, was slowly progressive and was aggravated by mild exertion. He had also had a mild non-productive cough of four years duration.

In January 1953, he had an episode of hemoptysis of 2 to 3 days duration. At that time a chest x-ray and Bronchoscopic examination were within normal limits. Again June 11, 1954 he had a second episode of hemoptysis and following this continued to expectorate blood streaked sputum daily until his present admission.

Past History

He worked in both hard and soft coal mines from age 14 to age 54. For the past several years he has been employed by the Waverly Hills Tuberculosis Sanatorium. He has smoked two packages of cigarettes daily for forty years.

Physical Examination

The patient was well developed and moderately obese. He was mildly dyspneic at rest, more so during ordinary conversation. His admission weight was 178 lbs. and his height 64 ½ inches. His temperature was 99° F. orally, pulse rate 84/min, respiration 20/min and blood pressure 126/80. He appeared plethoric and cyanotic. There was no distention of the neck veins. There was mild dorsal kyphosis. The PA diameter of the thorax was increased. The chest measured 117 cm. in expiration and 120 cm. in inspiration. Chest expansion was equal bilaterally. Diaphragmatic motion was only slightly diminished. Breath sounds were vesicular in type. There were no rales. The cardiac size was normal and the apical impulse was neither palpable nor visible. There were no murmurs or friction rubs. The liver and spleen were not enlarged and there was no pedal edema.

Laboratory Studies

RBC 6,590,000/cmm, hemoglobin 18.0 gms. WBC 7,000 per/cmm, platelets 369,040, hematocrit 64, MCV 97.4, MCH 27.3, MCHC 28.2, reticulocyte count 0.6%. There were no immature cells on stained film of peripheral blood. Urinalysis was not remarkable. Liver function studies were normal. Three sputum smears for acid fast bacilli were negative. The electrocardiogram was normal.

The serum chloride was 94 mEq/L and the CO_2 content was 35.2 mos. The arterial blood 0_2 saturation was 84.7% and the arterial blood pH was 7.4. The vital capacity was 2023 cc (66.5% of predicted normal), walking ventilation 17.4 L/min, maximum breathing capacity 48.5 L/min. (66.5% of predicted normal). His dyspnea index (walking ventilation/MBC) was 0.35. The air velocity index was 1. There was no significant change in pulmonary function after the administration of a bronchodilator drug (Isuprel by inhalation).

The histoplasmin and tuberculin skin tests were positive. The venous pressure was 80 mm saline and the arm to tongue circulation time by Decholine was 18 seconds.

X-RAY DISCUSSION: L. A. Davis, M.D.

The lung markings are more prominent, straighter than normal and run to the periphery of the lung fields. The intervening lung parenchyma is more radiolucent than usual. The sides of the diaphgram seemed somewhat depressed. These changes suggest a diffuse emphysema with some fibrosis but do not indicate the etiology of the emphysema.

Case Discussion

A. I. Urgancioglu, M.D., and Grover B. Sanders, M.D.

The shortness of breath immediately directs attention to the cardio-pulmonary system. Heart disease with congestive failure can be excluded by the normal size

and configuration of the cardiac shadow, a normal circulation time and venous pressure, a normal electrocardiogram and the absence of pulmonary congestion and peripheral edema. Other less common etiologic factors, such as anemia and certain diseases of the nervous system, can likewise be excluded. The history of dust exposure, the shortness of breath and the physical findings on chest examination along with the radiological and blood chemistry findings strongly suggest the presence of primary lung disease. The blood findings, the increase in packed cell volume, the RBC count and hemoglobin with normal WBC and platelet count, the absence of immature cells in the peripheral blood smear and a normal sized spleen are in favor of secondary polycythemia rather than polycythemia vera. We are, therefore, dealing with a case of pulmonary insufficiency with secondary polycythemia.

The exact cause of the hemoptysis has not been determined. In a patient of this age it is commonly due either to bronchiogenic carcinoma, pulmonary infarction, tuberculosis or bronchiectasis. The first three have been reasonably well excluded.

Pulmonary function studies were done to verify our clinical impression and to determine the degree of pulmonary insufficiency. Pulmonary insufficiency can be divided into two general groups, one ventilatory and the other alveolar capillary (respiratory gas exchange). Ventilatory insufficiency may be further divided into restrictive and obstructive types, in both of which dyspnea is the chief clinical manifestation. Impairment respiratory gas exchange is clinically manifest as anoxia and hyperventilation regardless of whether the underlying defect is one of distribution of inspired gas or of diffusion across the alveolar capillary membrane. It is unusual to find a patient demonstrating either type of impaired function in a pure form, most presenting abnormalities in both ventilation and gas exchange as is demonstrated by this patient.





Impaired ventilation is well demonstrated here. The reduced arterial oxygen saturation probably is due to impaired ventilatory function as well as to the abnormal respiratory gas exchange. A timed vital capacity and a residual volume determination would have been very helpful but unfortunately these tests were not available. Considering the clinical findings along with the laboratory studies it becomes apparent that this is a case of pulmonary fibrosis with emphysema. It can be postulated that his pulmonary fibrosis and emphysema are due to anthracosilicosis. These cases are subject to repeated infections resulting in variable degrees of interstitial fibrosis, bronchitis, bronchiectasis and emphysema.

Treatment of advanced emphysema and pulmonary fibrosis is generally discouraging. Nevertheless there are cretain measures which are helpful in obtaining considerable improvement in pulmonary function and in affording a measure of com-

fort to the patient. The primary consideration should be directed toward prevention of progression of the disability by removing or controlling those factors which aggravate the disease. Infection should be kept under control by proper antibiotic therapy. Irritating inhalants such as dust and cigarette smoke should be avoided. Broncho dilators may be helpful in the presence of bronchial spasm or obstruction. Breathing exercises, abdominal binders and pneumoperitoneum have been of value in selected cases. In instances of associated secondary polycythemia phlebotomy with removal of 500 cc. of blood at appropriate intervals comprises one of the most important therapeutic measures. Digitalis preparations, diuretics and salt restriction should be used in the event of congestive heart failure. Administration of oxygen either intermittently or in low concentrations via nasal catheter may give added relief in advanced cases. The possibility of CO_2 narcosis and oxygen habituation should be kept in mind when oxygen is administered in cases of advanced pulmonary insufficiency.

SPECIAL ARTICLES

THE M. D. AS A PUBLIC SPEAKER*

RICHARD S. GRAVES, M. D.

Dayton, Ohio

There are three things at which the doctor is popularly considered to be *no good*. One is as a patient, two is as a business man and three is as a public speaker. I am just as guilty of the first two as any one else is, and I may be just as guilty of the third, but at least I can tell you how not to be.

Why should the medical doctor be a public speaker? Why is it important that he speak out in public?

In attempting to answer this question, one immediately comes face to face with the problem of public relations. Public relations in the practice of medicine. Prior to the second world war and going back to the early nineteen hundreds, doctors enjoyed inherently good public relations much in the fashion of firemen or policemen, when they were sent for they were really needed, and people were glad to see them. The doctor was an admired individualist. He represented self-sacrifice, hard work, unselfishness and community pride. Then, during the nineteen thirties and the years since, many subtle changes have taken place so that the importance of self reliance and individualism has been diminished and more and more dependence placed upon the government. Our economy has changed. The public attitude has changed. The result is that by some persons and in some communities the doctor has not been held in the same high esteem enjoyed by his predecessors. For example, ask your wife how often at club meetings she hears derogatory remarks directed at our profession. I'll wager, the only time she doesn't is at a meeting of the medical society auxiliary. Cussing out the doctor has become a national sport. The public, like an adolescent child has begun to stand up and talk back to its doctors. Doctors who up until recently had been accustomed to acceptance of their authority and wisdom. It is becoming more and more obvious that the patient wants to know the facts about his illness. The patient wants to know more about fees or else he becomes suspicious of a charge for an illness or an operation which he naturally did not want in the first place. The patient wants to be treated more congenially in the doctor's office. The patient would like to be seen in the office by appointment, and when the appointment cannot be kept, he appreciates having this fact explained to him. The patient wants to be reassured regarding the availability of his physician.

These are a few of the things with which the patient is concerned in his relationship with the doctor. There are others, many of them of less importance but they all add

*Read before the Fourth Annual County Society Officers' Conference of the Kentucky State Medical Association, April 15, 1954, Lexington, Kentucky.

up to the fact that there is need for a continued effort on the part of the doctor in his search for a healthier, a happier and a more compatible relationship with the public. In order to attain that type of relationship, we as physicians must exhaust every possible means of carrying our story to the public. They must be told what we are doing to overcome these problems. They must be acquainted with the physician's side of these various problems, which they sometimes feel are due to indifference, greed or lack of ethics on the part of the physician. They must be properly informed regarding problems of health, disease, operations and other medical questions. An effective speakers bureau is one of the most powerful means of accomplishing these things. Doctors themselves should and must assume the responsibility of appearing before public organizations.

In the January issue of the P.R. Doctor, which is issued by the public relations department of the American Medical Association, there is outlined the most important public relations goals for 1954. In every one of these goals there is a place for public speaking. It must be done by the local physician. We cannot hire nonprofessional personnel, such as advertising groups, nor can we expect any of our business associates, such as executive secretaries, to do the job for us. We must assume the responsibility. We must be there in person. The individual physician should be willing to appear before any and all groups that are interested enough to listen to him.

Now granted that we have shown there is a need for the M.D. to be a public speaker, how can he best accomplish it. I should like to discuss this question under three principal headings: 1. The speakers bureau. 2. The subject matter. 3. The presentation.

The most effective means of employing the physician as a public speaker is through a speakers bureau. The implementation of a speakers bureau is one of the basic functions of any public relations committee. Doctors with the ability and willingness to speak, supplied with proper materials, can do a great deal in improving the public relations of any county medical society. There are literally hundreds of women's clubs, school groups, social groups, civic organizations and other groups who are constantly looking for interesting and well-prepared speakers. It is an extremely fertile field and we as physicians should be planting the seeds of good public relations. The method of establishing a speakers bureau will need to be varied in accordance with the size and financial backing of the individual county medical society. In order to give you a specific example I should like to describe the manner in which we established our speakers bureau in Dayton.

First, it was realized that in order to establish a speakers bureau with full scale equipment, including such things as a film sound projector, slide projectors, screens, video boards, torso models, etc., financial backing would be necessary. Since no funds were alloted for this specific purpose, it was thought that perhaps the speakers bureau might be attached to one of the various other functions of the medical society which had sufficient funds to support it. Accordingly the bureau became a joint venture of the Cancer Control Society and the Montgomery County Medical Society. The Medical Society provided the speakers, and the Cancer Control Society provided the funds, the arrangements, and the purchase of equipment. Requests for doctors willing to accept invitations to speak before various lay organizations in Dayton and Montgomery County were mailed to all physicians in the county. The request listed a wide variety of topics suitable for presentation before a non-medical group. A brochure was then made up entitled S O S for Program Chairman, a copy I have here at hand. Literally translated it means, Speaking of Speakers. This brochure contains instructions regarding the method of obtaining a speaker from the Montgomery County Medical Society, and it includes the subjects available listed under the proper headings. A copy of this brochure was sent to all program chairmen, presidents and secretaries of all organizations in Dayton and Montgomery County and to various school and church groups. A return card was enclosed on which to request a speaker or speakers by topic. When an organization chose a particular topic, a physician who had previously volunteered for that subject was contacted to make the speech. When desired, films, slides, projection equipment, etc. are provided. Over one hundred physicians have volunteered their services in delivering these subjects, and speeches are presented in and around Dayton on the average of one a week. There are a few things we have learned should be followed in order to expedite the functions of a speakers bureau.

First, in order for a speakers bureau to

survive, it must be organized, supervised and managed by some permanent person or persons. Someone must be in charge. In larger medical societies, this may be the medical society's secretary or whatever person is in charge of the business functions of the medical society. In smaller groups or in smaller county medical societies, it might be the physician secretary of the medical society or it can easily be a physician appointed or elected for the specific purpose of managing a speakers bureau. Don't forget that it takes only one person to be a speakers bureau.

Secondly, once someone is placed in charge, then it should be made clear that all requests for speakers as well as the anticipated comments of the speakers should be cleared through the head of the speakers bureau.

Third of course, a record must be kept of who the speakers are and what subject they can and will discuss.

Fourth, whenever possible, the speaker should be given two weeks notice. In some instances where the individual has discussed the same subject a number of times, he may not require that much notice.

Fifth, the institution of the speakers bureau should be publicized. It should appear in the local newspaper, either as a news item or if necessary, as a paid advertisement. In addition a letter should be sent from the County Medical Society to all groups and Societies in the county, announcing the institution of a speakers bureau.

Sixth, liaison should be established with the local newspapers for advance and follow-up publicity when indicated.

Seventh, let it be known that the speakers bureau service is offered without charge.

The second principal consideration in answering how the M.D. can be a public speaker is the subject matter.

By and large the subjects should be of a general nature. However, there are several specific medical problems that seem to be of interest to lay groups. For example, heart disease, cancer, arthritis, sinus trouble, headaches and overweight just to name a few. General subjects of a medico-social nature seem to be quite popular. For example, public relations in the practice of medicine, why you need a family doctor, common emergencies—are you ready and socialized medicine.

Once you have chosen a subject, then dress up the title. Make it stimulate interest. For example, consider the picture your mind conjures up, when I say to you, the title of my talk will be, The Origin and Development of Radioactive Isotopes. Now compare that with the picture when I tell you that the title will be *From Witchcraft to Isotopes.*

Secondly, keep the title brief. Avoid long and impressive wording, else you may find after it is over that more was said in the title than in the body of the talk.

Thirdly, arrange the subject matter so that thoughts march along in a natural sequence.

The third principal topic that I mentioned is the presentation of the speech.

First it is well that the speaker insists upon a proper introduction. If we are to carry the word of our Medical Societies out to lay groups, let us be sure that the audience correctly understands the source and authenticity of the information. Also where indicated the speaker should request that adequate physical facilities, such as lights or other props be provided. Secondly, remember that the doctor does not have to be an orator. All he needs is the willingness to talk, the proper use of his native ability to speak and something important to say. Third, the speech should be presented in accordance with certain basic laws of public speaking. These, one can find in any one of several text books on the market today. Personally I have always liked the ideas proposed by Mr. Richard C. Bordan, who recommends presenting the speech according to listeners laws. Mr. Bordan points out a speech must be designed and presented to combat four successive audience reactions. One is ho-hum, two, why bring that up, three, for instance, four, so what.

The first sentence of a speech must break through that apathy. For example, the story is told about the great clergyman, Henry Ward Beecher who was about to speak in a small West Virginia town, widely known in lecture circles as having extremely stupid and indifferent audiences. When introduced, Mr. Beecher rose from his chair, wiped his brow with a large handkerchief and said in a loud voice, "It's a goddamn hot day." Every eye in the audience opened, and every person sat up straight in his chair. Mr. Beecher then went on to say, "That's what I heard a man say here this afternoon."

The second portion of a speech must answer the question, why bring this subject

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EDITORIALS

WHO IS THE BOSS?

The California State Medical Association, in an extensive advertising campaign, has brought a very important question on prepayment medical care plans to the attention of the people of California.

It asks the simple question: "ARE YOU THE BOSS" when you join a health insurance plan?"

"Being the boss in your insurance plan," the campaign literature points out, "is important to you and here is why:

1. It means that you can dismiss your doctor or your hospital and change to any other of your choice if you are not satisfied.

2. It means that you have full freedom in caring for your own health, just as you have in caring for all your other needs.

3. It means that you can have your own personal physician...a man you have full confidence in because he knows you as a person and not just as another 'case'."

The necessity for medicine selling the public on ideas that on their face should be obvious has been produced by the growth to prominence of such plans as the Kaiser Foundation Health Plan in California. The fact that almost every state in the union, including Kentucky, has some similar plan in operation or contemplation makes the problems they create important for the entire profession and the people of the whole nation.

There is no question but what the presence of the third party in the economics of medical care is here to stay. The big question is, shall the patient be boss, or shall the third party be boss? Is the patient to lose his independence when once he has selected a plan and paid his money?

It is far from simply being a concern of the physician. Of great importance is the freedom to the patient.

Anyone familiar with the growth of this type of financing medical care knows that frequently organization of such plans springs from motives that are idealistic in character. This has brought to them support from people with the highest motives, however misguided. This makes it all the more important that the public be informed about the dangers they entail.

Because the Kaiser plan has received so much national attention, it serves well as an example which might be held up in this type of medical care plan.

The Kaiser plan received its greatest boost to national prominence from Paul de Kruif, famed lay medical writer, in his book, "Kaiser Wakes the Doctors." His disappointment with the ultimate nature of the plan's growth and his clearer understanding of some of the apparently inherent problems involved were well set forth in an article in "The Bulletin of the Los Angeles County Medical Association," entitled "One Man's Experiences with the Kaiser Plan."

He opened his article as follows: "This is a confession of personal error and a statement of what the present writer learned as a result of that mistake."

Subsequently, in the article he writes, "This writer pointed out to Mr. Henry J. Kaiser and Dr. Sidney R. Garfield (head of the Kaiser medical staff) that the medical staff of their organization could not progress without intimate, cordial and constant contact with organized medicine...

"This is what the Kaiser-Permanente authorities said they wanted. And so, to test their intent, the present writer was instrumental, again and again, in bringing together top level representatives of Kaiser-Permanente with top level representatives of organized medicine, county, state and national. The record of these conferences is a sad story of misunderstanding and failure. Of course it takes two sides to make a fight. Yet the present writer with regret must report, that a certain atmosphere pervaded these conferences, as follows:

"The representatives of organized medicine asked one change in Kaiser- Permanente's procedure as a condition essential to organized medicine's cooperation. Namely, that the closed panel be changed to open panel; that subscribers to the Permanente plan, if they wished the services of physicians or surgeons other than the full time medical employees of Kaiser- Permanente, could have that service and be indemnified for it. This to the present writer seems reasonable.....

"Against this proposal by organized medicine's representatives, Kaiser-Permanente's officials have been obdurate. Again and again, Kaiser-Permanente's principals assured this writer that the medical profession as a whole hated and feared Kaiser-Permanente, that Kaiser-Permanente was persecuted by organized medicine. A curious and contradictory dichotomy, seems, to the present writer, to pervade the thinking of the Kaiser-Permanente authorities.

"On the one hand, they say organized medicine has nothing to fear from the growth of Kaiser-Permanente, indeed, that Kaiser-Permanente's existence will make the private practice of medicine more prosperous. On the other hand they believe that the private practice of medicine as we know it is outmoded and will soon be a thing of the past.

"If the present writer had been less stupid, he would have seen the futility of trying to bring Kaiser-Permanente and the medical profession together. This writer should have taken warning, long ago, from Dr. Sidney R. Garfield's point of view regarding the relationship between patients and their doctors.

"According to Dr. Garfield, this human relationship is no longer necessary. According to Dr. Garfield, teamwork by specialists streamlined under a hospital roof has made the doctor-patient relationship obsolete...

"To the present writer this point of view seems a bit premature. Has medicine really become so scientific that cold technique can completely replace warm human understanding, that medical robots can replace medicine's human practitioners, just as guided missiles promise to make human jet and bomber pilots things of the past?

"This production-line point of view of the Director of Kaiser-Permanente became more and more disturbing to the present writer as he took up study of the Alameda plan. The personal physician, the new man of medicine, emerging in California, is a medical advance fully as important as the new anti-biotics, vitamins and hormones. Indeed, the chemical revolution has put a new mighty power into the hands of general practitioners. They can understand and love their patients as of old and at the same time treat them more skillfully than could the greatest specialists in many fields, ten years ago. Kaiser-Permanente medicine is an anachronism, built rigidly as it is around specialist teamwork, in some specialties already in their twilight.

"In the Kaiser-Permanente health plan there is no room or function for the personal physician, the new man of medicine. The personal physician must be his own man, must be free.....

"As citizens, as sick and suffering people, what do we want from our doctors? We want much more than prepaid medicine at a few cents a day and more than an airconditioned room in a hospital that is an interior decorator's dream. We want love from our doctors—plus knowledge of how to use what's new in science."

What Paul de Kruif says is undoubtedly true. And what the California State Medical Association implies in its question to the people of California is equally true. There is no place in the highest type of medical care for a third party who will be the boss. Place for the third party there may be, but not as boss. Because then is not only lost the essence of the patient-physician relationship, but freedom as well.

WILLINGNESS TO SERVE—AN ESSENTIAL OF LEADERSHIP

Although we frequently sing and write of the blessings, freedom and opportunities entailed in the democratic way of life, we too often forget that certain responsibilities go along with these very apparent advantages.

This is as true in Kentucky as it is in Washington, and it is equally true of every organization to which we may belong.

David M. Cox, M.D., President of the Jefferson County Medical Society, must have had this thought in mind when he wrote his message for the June issue of "News Notes." In his monthly letter to the membership he commended the hard-working members of his 27 committees and cited the contribution they are making gratis to the public and to the profession.

"Their only reward is in the satisfaction of being able to be of service to their Society and their community," Doctor Cox says with justifiable pride. Certainly the same can be said for the several hundred physicians who compose the 50-odd K.S.M.A. Committees, whose members

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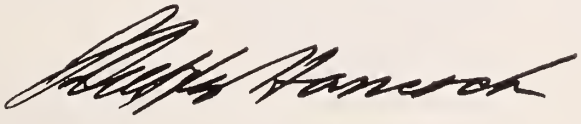
President's Page

Our Kentucky State Medical Association is an organization with many wide-spread interests. While its primary purpose is to protect the health of the people of this Commonwealth, the implementation of the project requires innumerable hours of hard work by many of our members.

We have a most efficient staff at the headquarters office headed by Mr. Joseph P. Sanford, our Executive Secretary. Our field representative, Mr. John Guy Miller, has been very enthusiastic in his arduous work on varied assignments throughout the State. Active and helpful as the members of this group are, they are kept busy carrying out the instructions given by your representatives. They have neither the time nor the authority to determine policies.

Policy making is the province of our House of Delegates, Council, and Executive Committee. These decisions depend upon recommendations made by various committees after much investigation and deliberation. There are in excess of fifty such committees, each having from five to seven members donating their time and services.

In this, my last article on the President's Page, I want first to acknowledge publicly the value of their contributions. I have met with many of them and well know the fairness, sincerity and thoroughness which they have exercised. Lastly, I want to thank them just as publicly for their conscientious and self-sacrificing services. It was a real pleasure to work with them and to have the opportunities to know them better.



PRESIDENT

ORGANIZATION SECTION

Scientific Exhibits Announced For Annual Meeting

Fifteen carefully prepared scientific exhibits will highlight the KSMA Annual Meeting in Louisville, September 21, 22, and 23, and serve as a valuable supplement to the entire scientific program, stated Everett L. Pirkey, M. D., Louisville, chairman of the Committee on Scientific Exhibits.

"This year the Annual Meeting will have an exceptional array of approved exhibits covering a wide range of recent medical and scientific developments which should be of interest to all KSMA members," Dr. Pirkey said.

Listed below are the 15 scientific exhibits:

"Clefts of the Face," by Andrew M. Moore, M. D., Lexington, and the Dorton, Webb, Royalty and Moore Surgical Group, Lexington;

"Research in Plastics," by Milton C. Cobey, M. D., Georgetown University, Washington, D. C.;

"Stenotic Valvular Disease," by Thomas J. E. O'Neill, M. D., O. Henry Janton, M. D., and Robert P. Glover, M. D., Philadelphia, Pennsylvania;

"Differential Diagnosis of Breast Tumors," by the Kentucky Division of the American Cancer Society, Louisville;

"Surgery in Advanced Skin Cancer," by John J. Wolfe, M. D., University of Louisville School of Medicine and the Veterans Administration Hospital, Louisville;

"Epitheliomas of the Skin," by Ullin W. Leavell, Jr., M. D., Lexington;

"The Heart Association Helps the Physician," by J. P. Holt, M. D., Kentucky Heart Association, and the American Heart Association, Louisville;

"Allergenic Pollens, Plants and Molds of Kentucky," by M. Kaufmann, M. D., and L. D. Mayer, M. D., Lexington;

"Differential Diagnosis in Pulmonary Disease," by the Kentucky Trudeau Society, Louisville;

"Surgery of the Neck," by Howard E. Dorton, M. D., Lexington, and Dorton, Webb, Royalty and Moore Surgical Group, Lexington;

"Vaginal Hysterectomy," Laman A. Gray, M. D., Department of Obstetrics and Gynecology, University of Louisville School of Medicine;

"A Model Laboratory," by the Kentucky State Society of Medical Technologists, Louisville;

"Early Mouth Cancer," by Condict Moore, M. D., University of Louisville School of Medicine;

"Differential Diagnosis of Painful Anorectal Conditions," by Wilford J. Cooper, M. D., of the Lexington Clinic, Lexington;

" Medical Uses of Radioisotopes," by Herbert D. Kerman, M. D., Radioisotope Laboratory, University of Louisville School of Medicine.

"Medic," New TV Series, Starts Sept. 13, Over NBC

"Medic," a dramatic new weekly television series based upon true-to-life experiences of physicians, will make its initial appearance on Monday, September 13, at 8 p.m., Daylight Time, over the National Broadcasting Company's television network.

The new series is commercially sponsored and is presented in cooperation with the Los Angeles County Medical Association. The dramatic material is ethical, realistic, and authentic, according to official medical sourses.

Kentucky physicians have been urged by KSMA president, J. Duffy Hancock, M.D., Louisville, who has previewed some of the shows, to see these new dramatic presentations. Numerous communications from the public are expected when these intensely life-like dramas are shown.

Dr. Hancock, along with AMA officials, believe that "Medic" will do much to give the public a true picture of real problems faced daily by the medical profession.

Four Scientific Movies Highlight Annual Meeting Program

Four scientific movies of general interest to KSMA members have been carefully selected by the Committee on Medical Education to be shown at intervals during the Annual Meeting in Louisville, September 21, 22, and 23, it has been announced by Lawrence Minish, M. D., Louisville, chairman.

"Open Method of Burn Therapy," by John C. Weeter, M. D., Louisville, will be shown in the main auditorium of Columbia Auditorium at 1:30 p. m., Tuesday, September 21, under the direction of Mr. Frank Shook, head of the

(Continued on page 706)



The Annual President's Luncheon will feature presentations by Governor Lawrence W. Wetherby and Nicholas P. Dallis, M.D., Toledo psychiatrist, and his two artists, Marion Bradley and Frank Edgington. The Committee on Arrangements urges that you make your reservations early for this very popular meeting which will start at 12 noon, Daylight Time, Wednesday, September 22.

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Department of Visual Aids of the University of Louisville.

A morning feature, "BCG Vaccination," sponsored by the American Trudeau Society and Research Foundation of the University of Illinois School of Medicine, will be presented at 8:30 a. m., Wednesday, September 22.

"The Problem of Rheumatoid Arthritis," presented by the Kentucky Chapter of the Arthritis and Rheumatism Foundation, will be shown at 8:30 a. m., Thursday, September 23, according to R. L. McClendon, M. D., chairman.

Final presentation of the scientific movie program will be "A Series of Cases Showing Unusual Types of Short Seizures," by Irving O. Dein, M. D., and Ephraim Roseman, M. D., Departments of Neurology and Visual Education, University of Louisville School of Medicine. This movie will be shown at 1:30 p. m., Thursday, September 23.

KSMA Features Blood-Testing Machine at State Fair

Detection of the unknown diabetic is being carried into the 1954 Kentucky State Fair, now in progress, by means of the KSMA Exhibit which is devoted to diabetes and features actual demonstrations of the "Clinitron," an automatic blood sugar testing machine, according to W. Vinson Pierce, M. D., Covington, chairman of the KSMA Education Campaign Committee, which has overall responsibility for the association's booth at the state fair each year.

The actual direction of the exhibit on diabetes and the blood-testing program in connection with it is under the direction of the KSMA Diabetes Committee of which Carlisle Morse, M. D., Louisville, is chairman. The Diabetes Committee requested use of the KSMA booth so as to provide additional impetus to its annual Diabetes Detection Drive, scheduled for November 14-20 this year, and its overall program of diabetes education in cooperation with the American Diabetes Association.

Demonstrations of the "Clinitron," which is being shown for the first time in Kentucky, is expected to uncover new diabetics among the volunteers taking the blood sugar test at the same time that the whole exhibit gives the public a better understanding of diabetes, its cause and control. The machine being used was obtained on loan from the Division of Special Health Services, U. S. Public Health Service, Washington, D. C. The "Clinitron" is being used in conjunction with an exhibit prepared by the American Diabetes Association.

Room Assignments Announced for Specialty Group Meetings

The eight specialty groups, which will convene simultaneously Wednesday afternoon, September 22, 1954, during the Annual Meeting of the KSMA, have been assigned individual meeting rooms in the Columbia Auditorium, according to J. Duffy Hancock, M. D., Louisville, chairman of the Committee on Scientific Assembly.

Members of the association may choose one or more programs they wish to attend and should feel free to move from one group meeting to another during these specialty group sessions, Dr. Hancock added.

Beginning at 2:00 and 2:30 p.m., Wednesday afternoon, the specialty groups will hold half-hour presentations until 3:00 p.m., when there will be a 30-minute intermission to visit the exhibits. Two more half-hour presentations will be given, starting at 3:30 p.m.

Following is the name of each society and its meeting room in the Columbia Auditorium:

Room No. 1—Kentucky Society of Anesthesiologists (First Floor)

Room No. 2—Kentucky Chapter, American College of Chest Physicians (First Floor)

Room No. 3—Kentucky Chapter, American Academy of General Practice (First Floor)

Room No. 4—Kentucky Obstetrical and Gynecologic Society (Lower Level)

Room No. 5—Kentucky Chapter, American Academy of Pediatrics (Lower Level)

Room No. 6—Kentucky Chapter, American College of Physicians (Lower Level)

Room No. 7—Kentucky Psychiatric Association (Lower Level)

Room No. 8—Southeastern Surgical Congress (Second Floor)

Almost 100 Diabetes Chairmen Named for '54 Campaign

With 97 county medical societies having reported their Diabetes Committee chairmen for the 1954 Diabetes Detection Drive, scheduled for November 14-20, plans for this life-saving campaign are further along than at the same time in any previous year since the Kentucky State Medical Association began annual sponsorship of the program, according to Carlisle Morse, M. D., Louisville, KSMA Diabetes Committee chairman.

"Each year we have seen a more ready acceptance by county medical societies and individual physicians of the importance of this

diabetes education and detection project," Dr. Morse said. "If the response from county medical societies to the Committee's request that they name Diabetes Committee chairmen early is accurate harbinger, we may expect to again surpass the results of previous years in this public service."

This will be the fourth year that the KSMA in cooperation with the American Diabetes Association, has sponsored the state-wide Diabetes Detection Drive as a part of National Diabetes Week. During the week of November 14-20, each physician who is a member of the KSMA will be asked to give free urine sugar tests to all requesting it. Reagents are supplied through the Diabetes Committees.

The purpose of the campaign, which is under physician direction nationally as well as in Kentucky, is to detect as many previously undiscovered diabetics as possible. According to the American Diabetes Association, there is one undetected diabetic in the nation for each known diabetic—approximately 15,000 in Kentucky.

As a part of the overall education and detection activities of the Diabetes Committee, diabetes will be a feature at the KSMA State Fair Exhibit September 10-19, 1954. Details on the exhibit appear elsewhere in this issue of the Journal.

Taylor County Society to Sponsor Four Medical Forums

A series of four medical forums will be presented without charge to the public under the joint sponsorship of the Taylor County Medical Society and the Campbellsville News-Journal, it has been announced by W. Burr Atkinson, M. D., Campbellsville, president of the society.

Topics for the forums include: "The Miracle of Childbirth," September 10; "Public Enemy No. 1," November 12; "You Are as Good as Your Heart," February 11, and "Medicines and Drugs—Friends or Enemies?", April 8.

Every member of the Taylor County Medical Society has agreed to serve on a discussion panel. Participating Campbellsville physicians include: R. D. Barton, M. D., Roy G. Wilson, M. D.; M. M. Hall, M. D.; L. S. Hall, M. D.; C. V. Hiestand, M. D.; W. W. Shepherd, Jr., M. D.; H. F. Chambers, M. D., and Dr. Atkinson.

The purpose of the series is to give the public an opportunity to have their questions on these medical topics answered. At each meeting two Taylor County physicians will make brief talks to provide background information for the discussion of audience questions.

The free medical forums are to be held at the Campbellsville High School Auditorium at 7:30 p. m. The American Medical Association and the Kentucky State Medical Association have endorsed the projected free medical forum series. Similar forums have been presented in Paducah by the McCracken County Medical Society.

First Issue of 'KYGP News' Is Distributed in Sept.

The first issue of "KYGP News," the new official publication of the Kentucky Chapter of the American Academy of General Practice, is being distributed during September to its members, also to interns and residents in all Kentucky hospitals, according to Garnett J. Sweeney, M. D., Liberty, president of the Academy.

"KYGP News" will be an up-to-date bulletin designed to inform members of meetings and news of general interest, in addition to containing editorials of a scientific and socio-economic nature and scientific contents," stated Carroll Witten, M. D., Louisville, the editor.

He added that scientific material would include abstracts of papers not carried in other publications, formal papers, and occasional scientific material obtained from Clinical Pathological Conferences. The November bulletin, the second and final issue to be published in 1954, will be the first to contain scientific material. During 1955, the Kentucky Academy expects to distribute "KYGP News" to its members and other readers each month.

The cost of the publication will be borne by the Kentucky Chapter of the American Academy of General Practice and such revenue as is derived from advertising, Dr. Witten said. Charles Bryant, M. D., Louisville, will serve as Chairman of the Editorial Board. Members are Thomas Gudex, M. D., Louisville, and Burl Mack, M. D., Pee Wee Valley.

M.D.'s Plan New Office Building

A new office building at the corner of Preston Street and Eastern Parkway, Louisville, may be erected by a group of Louisville physicians who are seriously considering the project, according to Henry Asman, M. D., chairman of the Committee investigating the matter.

Office space would not be limited to any special group and any physician desiring rooms would be eligible to apply, Dr. Asman said. Subsequent developments on the building project, to be located on ground purchased from the St. Joseph Infirmary, will be carried in a future issue of the Journal.

Ky. Radio Stations Carry AMA Programs as Public Service

A total of 27 Kentucky radio stations in as many communities throughout the state are cooperating with county medical societies and the KSMA by broadcasting the AMA transcribed radio programs as a public service, it has been reported by W. Vinson Pierce, M. D., Covington, chairman of the KSMA Education Campaign Committee, which has responsibility for the project.

"It is reasonable to assume that there is no place in Kentucky which is beyond reach of these excellent health education broadcasts," Dr. Pierce said. "Hundreds of thousands of people obtain a better understanding of American medicine and its objectives in consequence of splendid cooperation we are receiving from the radio stations of Kentucky."

The KSMA began its function as a statewide distributing center for AMA transcriptions slightly over a year ago, with active promotion by the Education Campaign Committee.

The radio stations carrying the broadcasts put them on the air at least weekly. All are fifteen minute programs, professionally prepared by the AMA Bureau of Health Education, and are presented in series of 13.

The following are the stations and cities participating in the radio broadcasts:

WCMI, Ashland; WLBJ, Bowling Green; WLCK, Campbellsville; WAIN, Columbia; WCTT, Corbin; WHIL, Danville; WIEL, Elizabethtown; WFKY, Frankfort; WKAY, Glasgow;

WHLN, Harlan; WKIC, Hazard; WSON, Henderson; WLEX, Lexington; WFMW, Madisonville; WNGO, Mayfield; WTFM, Maysville; WMIK, Middlesboro; WNBS, Murray;

WNOP, Newport; WVJS, Owensboro; WSIP, Paintsville; WLSI, Pikeville; WPRT, Prestonsburg, WPKY, Princeton; WSFC, Somerset, WTCW, Whitesburg; WMTC, Van Cleve.

District 6 Holds Dinner Meeting At Glasgow, August 10

Members of the Sixth Councilor District of the KSMA were guests of the Barren County Medical Society for a dinner meeting and scientific program August 10, at the Community Hospital in Glasgow, according to an announcement by Richard F. Grise, M. D., secretary of the district.

Lewis Dickinson, M. D., Glasgow, discussed "Functional Diseases of the Respiratory System," on the scientific program, and C. G. Follis, M. D., Glasgow, talked on "Some Problems of Differential Diagnosis Between Gall Bladder Diseases and Diseases of the Pancreas." W. H. Cloyd, M. D., director of the Tuberculosis Hospital at Glasgow, presented "A Few Interesting Chest Cases."

In addition to sixth district members, Barren County Medical Society was host to guest-physicians from the six adjoining counties of Grayson, Hart, Green, Taylor, Russell, and Clinton.

Preliminary Plans Discussed for Rural Health Conference

The Kentucky Rural Health Council program committee met August 13 at the Kentucky Farm Bureau Federation building, St. Matthews, to discuss plans for the 1955 Kentucky Rural Health Conference, according to Wyatt Norvell, M. D., New Castle, council president.

It was tentatively agreed that the 1955 Rural Health Conference will be held in Louisville and that it will be a one-day meeting. In the previous three conferences, the program has extended over parts of two days.

The program committee is headed by Paul Grubbs, information director of the Kentucky Farm Bureau Federation. In addition to Dr. Norvell, the committee includes Vice-Chairman of the Council Miss Myrtle Weldon, University of Kentucky Extension Division, and representatives from six other member organizations of the Council.

New Members Appointed to Board of Consultants

Eight carefully chosen KSMA physicians have been appointed to serve a three year term on the Board of Consultants on Scientific Articles which is responsible for reviewing scientific material submitted to the Journal for publication, according to an announcement by Bruce Underwood, M. D., Louisville.

Newly appointed consultants include: Carey C. Barrett, M. D., Lexington; Joe Bush, M. D., Mt. Sterling; Allen E. Grimes, M. D., Lexington; Richard F. Grise, M. D., Bowling Green; Billy Keller, M. D., Louisville; A. J. Miller, M. D., Louisville; Robert Reeves, M. D., Paducah; Charles R. Yancey, M.D., Hopkinsville.

Dr. Underwood explained that the Board is composed of 24 members. Under a system of rotation, eight members are appointed each year for a three year term and are not eligible to succeed themselves.

Retiring members of the Board are: Spafford Ackerly, M. D., Louisville; Sam Black, M. D.,

Louisville; Sam H. Flowers, M. D., Middlesboro; William P. Hall, M. D., Paducah; E. W. Jackson, M. D., Paducah; Tom Meredith, M. D., Harrodsburg; James E. Moore, M. D., Ashland, and Winston U. Rutledge, M. D., Louisville.

Joining Dr. Underwood is Guy Aud, M. D., Louisville, chairman of the Advisory Committee to the Editor, in a statement of appreciation to the eight retiring members of the Board for the splendid contribution these men have made to the improvement of the Journal and for the valuable service they have rendered to the association.

Special Program Sept. 17 Honors J. Watts Stovall, M.D.

J. Watts Stovall, M. D., Grayson, president of the KSMA in 1945 and a leading citizen in Carter county, will be honored on a "This Is Your Life" type of program at the annual Friends of School Day Picnic at Carter Caves State Park, sponsored by the Carter County Teachers' Association, September 17.



Dr. Stovall

One facet of Dr. Stovall's numerous activities despite his busy life as a physician for almost 50 years, has been his service as a member of the Grayson Board of Education for 12 years. Also, he is beginning his 10th year as the School Daddy of Upper Wilson, a rural school in the county. School Daddies are an association of men in the county pledged to improve attendance of rural children at school.

J. Duffy Hancock, M. D., Louisville, KSMA president, will appear on the program. In addition, Clyde C. Sparks, M.D., Ashland, KSMA president-elect, Wyatt Norvell, M. D., New Castle, vice-president, and Charles B. Johnson, M. D., Russell, councilor for the Thirteenth District, will represent the association in their official capacity. Councilors J. M. Stevenson, M. D., Brooksville, Ninth District, and Hugh Mahaffey, M. D., Richmond, Eleventh District, have received a special invitation to attend.

At 72, Dr. Stovall is President, Superintendent and Chief Surgeon of the J. Q. Stovall Memorial Hospital in Grayson, established in honor of his father who was also a physician and with whom Dr. Stovall began his practice as a youth of 22. At present, he is Vice-President of the Kentucky State Board of Health.

Professional colleagues are extended a special invitation to attend the program honoring Dr. Stovall which will begin at 10 a. m., Central Standard Time. Carter Caves State Park is located just off U. S. 60 between Olive Hill and Grayson.

Response to Golf Association Is Good, Chairman States

Response to the membership drive for the newly organized KSMA Golf Association has been gratifying and indicates a growing interest among association golfers for friendly competition in the KSMA Annual Meeting Golf Tournament, stated Clifton G. Follis, M. D., Glasgow, chairman of the KSMA Golf Committee.

He urged all who are interested in playing in the Golf Tournament at Audubon Country Club, Louisville, to send their membership fee of $5.00 to his committee at the Headquarters Office, 620 South Third Street, Louisville. Payment of this fee will enable the committee to offer attractive trophies and prizes to the winners in the tournament.

Dr. Follis added that KSMA members and their guests may play golf during the Annual Meeting without belonging to the Golf Association, but they will not be eligible to win any of the trophies.

The Audubon golf course will be open to KSMA physicians and their guests Monday, September 20 through Thursday, September 23. Only the first day of play of any member will count in the contest for tournament prizes, however.

Dr. Moorman, Centennial Speaker Dies in Oklahoma

Lewis J. Moorman, M. D., a native of Leitchfield, who was a leading tuberculosis authority in the United States, died at his home in Oklahoma City during the month of July at the age of 79.

At the KSMA Centennial Meeting in 1951, Dr. Moorman carefully prepared and presented a distinctive historical feature built around the life and deeds of Ephraim McDowell, M. D., whom the meeting commemorated. Interested in Kentucky history, Dr. Moorman did an amount of research in this field.

Dr. Moorman was a past president of the National Tuberculosis Association and for 30 years was president of the Oklahoma County Health Association. For the past 15 years he had been secretary-editor of the Oklahoma

State Medical Journal and was the author of two books.

In addition, Dr. Moorman was president of the Southern Medical Association, and was a Dean of the Oklahoma School of Medicine. He was a graduate of Georgetown College and received his medical education at the University of Louisville School of Medicine.

AOA Delegates Approve AMA's On-Campus Inspection

The House of Delegates of the American Osteopathic Association voted approval of the AMA's suggestion to conduct on-campus observations of osteopathic schools, this fall, at a meeting in Toronto, Canada, July 15, 1954.

The purpose of the AMA's inspection is to determine the quality of medical education provided by osteopathic schools and to settle the justification or lack of justification of the 'cultist' appellation of modern osteopathic education, according to a progress report presented at the AMA June meeting in San Francisco.

Each school will be visited by two members of the AMA's Committee for the Study of Relations Between Osteopathy and Medicine, accompanied by an individual of established experience in inspection of medical schools. The studies will be of sufficient duration, breadth and depth to establish the nature and scope of the educational program.

Committee Members Selected for New Ky. Trudeau Society

Committees to serve the newly organized Kentucky Trudeau Society have been named, according to Robert J. Dancey, M.D., Madisonville, president. The selections were made at a meeting of the executive committee at Pennyrile State Park.

The committees are: Membership, Edward J. Murray, M.D., Lexington; Lawrence Taugher, M.D., Louisville; Richard E. Mardis, M.D., Madisonville: Boyce Jones, M.D., London; Medical Education, Duane Jones, M.D., Ashland; Frank Stewart, M.D., Louisville; Robert R. Starr, M.D., Glasgow;

Program, John Harter, M.D., Louisville; Joseph K. Newton, M.D., Outwood; Daniel N. Pickar, M.D., Louisville; Harry T. Overby, M.D., Paintsville; Nominating, Oscar O. Miller, M.D., Louisville; Isadore Zapolsky, M.D., Paris; and Lawrence O. Toomey, M.D., Bowling Green.

In addition to Dr. Dancey, members of the executive committee are: E. R. Gernert, M.D., Louisville; Adam Miller, M.D., Lexington; Richard L. Colley, M.D., Mayfield, and Richard R. Crutcher, M.D., Lexington.

Membership in the society is open to all physicians and medical students interested in diseases of the chest. Applications for membership, along with the annual dues of $2.00 should be sent to Edward J. Murray, M.D., Julius Marks Sanatorium, Lexington, or any other member of the membership committee. A one-day tuberculosis case conference is planned for November in Lexington.

Civil Defense Barbecue Given By Dr. Gaither, Aug. 17

Gant Gaither, M. D., Hopkinsville, was host to a number of KSMA physicians and their wives from Western Kentucky, who attended a barbecue and special Civil Defense program, featuring four national and state speakers, August 17, at the Hopkinsville Country Club.

John Whitney, M. D., Washington, D. C., director of the Casualty Care Division of the National Civil Defense Organization, was the principal guest speaker on the program, along with Senator John Sherman Cooper, Somerset, and Representative Noble Gregory of the first congressional district.

In addition Leon Higdon, M. D., Paducah, vice-president of the KSMA, and Delmas M. Clardy, M. D., Hopkinsville, councilor for the Third District, gave a talk. A reception for the speakers was held in the afternoon, followed by the barbecue and evening program. Dr. Gaither, a member of the KSMA Committee on Emergency Medical Service, arranged for the speakers to appear on the program.

All physicians and their wives were invited who live in Daviess, Ohio, Butler, Warren, or Simpson counties and all counties west of these.

New M.D.s Take Residencies In Kentucky Hospitals

The following recently licensed physicians have entered a number of Kentucky hospitals as residents. All listed below were graduated from the University of Louisville School of Medicine in 1953, have finished a year's internship, and were licensed in the state of Kentucky as of July 1, 1954.

Children's Hospital, Louisville

Bernard W. Barron, M.D.; Alvin M. Churney, M.D; Leslie W. Langley, Jr., M.D.; Geraldine D. Paxton, M.D.;

General Hospital, Louisville

Norman K. Cohen, M.D.; Henry R. Glass, Jr., M.D.; John N. Goldsborough, M.D.; Olive R. Harris, M.D.; Russell F. Scalf, M.D.; Theodore A. Schramm, M.D.; Claiborne J. Walton, M.D.; Lolita S. Weakley,M.D.;

Good Samaritan Hospital, Lexington

David C. Asher, M.D.; William P. Grise, M.D.;

St. Joseph Infirmary, Louisville

John H. Doyle, M.D.; Wesley G. Farnsley, M.D.; Robert R. Kidd, M.D.;

Veterans Administration Hospital, Louisville

Warren A. Clark, M.D.; Ferrell C. Lowrey, Jr,. M.D., and William B. Triplett, M.D.

Dr. Hancock Addresses District 9

Approximately 60 members of the Ninth Councilor District and their guests heard J. Duffy Hancock, M.D., Louisville, KSMA president, speak on "KSMA Services," at a dinner meeting of the district July 22, at the Maysville Country Club.

J. M. Stevenson, M. D., Brooksville, councilor, who made the announcement, said featured speakers on the scientific program were Franklin Moosnick, M. D., Lexington, and V. Edward Masters, M. D., Louisville. The Mason County Medical Society was the host group.

Muldraugh Hill Meets Aug. 12

Highlights of a meeting of the Muldraugh Hill Medical Society, August 12, at Fort Knox, were a morning and afternoon scientific session, with a luncheon followed by a business meeting, according to Colonel A. L. Tynes, M. C., president.

Captain Maresh, M. C., P. W. Cummings, M. D., and Lt. Colonel Walter R. de Forest, M. C., presented individual case reports at the scientific session. Other speakers on the scientific program included Major Charles Liddell, M. C., H. Lester Reed, M. D., and Major Richard Walsh, M. C.

Dr. Smith Receives TB Citation

L. E. Smith, M. D., Louisville, received a citation from the National Conference of Tuberculosis Workers in recognition for his extended service in the battle against Tuberculosis, in July. Dr. Smith was executive secretary of the Kentucky Tuberculosis Association for 20 years. After resigning that post, he served a year as regional director of the State Board of Health. He retired last year.

Ohio Group to Meet Sept. 22-23

The Fourth Annual Scientific Assembly of the Ohio Academy of General Practice will be held Wednesday and Thursday, September 22-23, 1954, at the Deshler-Hilton Hotel, Columbus, Ohio, according to a release from the Academy.

Leo H. Bartmeier, M. D., Detroit, will discuss "The Human Side of Medicine" following the Banquet, Wednesday, September 22. A total of 14 outstanding scientific speakers will appear on the two-day scientific program.

Chest M.D.s Hold Luncheon

A luncheon meeting of the Kentucky Chapter of the American College of Chest Physicians will be held Tuesday, September 21, at 12:15 p. m., at the Brown Hotel in Parlors A, B, C, and D.

According to John Harter, M. D., Louisville, president of the Kentucky Chapter, featured guest speaker at the luncheon will be Thomas J. E. O'Neil, M.D., Philadelphia, Pennsylvania. His subject will be "Hypothermia and Mechanical Heart Lung Machine."

AMA Holds PR Institute

Three representatives from the Kentucky State Medical Association attended the AMA's 1954 Public Relations Institute held in Chicago, September 1 and 2. Highlights of the meeting included a TV Production Seminar and a preview of the AMA's latest film release "A Life to Save," to county medical societies.

Additional features included a PRoject Parade, in which state and county societies displayed their most successful PR activities and projects. Valuable PR tips on training the medical assistant and promotion of average fee schedules were other important topics on the agenda.

M.D.s Continue Education on TV

For the first time on September 23, a telecast for postgraduate medical education will be carried on a nationwide closed circuit hookup over the Columbia Broadcasting System to members of the American College of Physicians.

A panel of distinguished physicians including Cyrus C. Sturgis, M. D., Ann Arbor, Michigan, president of the American College of Physicians will appear on a "Symposium on the Management of Hypertension." A closed TV circuit is one by which reception is controlled

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and the invited audience must go to the TV receiving station. Twenty-three such receiving stations will be used; the closest station to the Kentucky area is Cincinnati.

Medical School Receives Grant

The University of Louisville School of Medicine was recently awarded $27,475 by the National Fund for Medical Education, according to an announcement by J. Murray Kinsman, M.D., Louisville, dean.

Under the grant each medical school receives $15,000 plus an additional $25.00 for each undergraduate student enrolled. The money given for unrestricted use will be applied primarily to teachers' salaries.

Used Medical Journals Needed

Back issues of medical journals and medical books are needed for a small library recently started at St. George's Mission Hospital in India, a charitable institution which serves indigent patients and operates on limited funds, according to a recent letter from T. K. Thomas, M.D., medical superintendent.

In addition to all types of medical literature, second-hand surgical instruments, medical appliances and laboratory equipment received from any KSMA members will be deeply appreciated, Dr. Thomas said. All medical supplies are difficult to obtain in this part of the world, Dr. Thomas continued. All material should be addressed to T. K. Thomas, M.D., Medical Superintendent, St. George's Mission Hospital, Punalur P. O., Travancore, S. India.

KSMA Welcomes 12 New Members

The following twelve new members have been added to the membership roster of the Kentucky State Medical Association as of July 22, 1954:

Harold Q. Davis, M. D., Richmond;
William Bruce Hamilton, M. D., Shepherdsville;
John Hemmer, M. D., Louisville;
Douglas H. Jenkins, M. D., Richmond;
George Kimbrough, M. D., Louisville
Laura Kimbrough, M. D., Louisville;
Elwin C. Lanz, M. D., Virgie;
David B. Lewis, M. D., Elizabethtown;
Paul Shakespeare, M. D., Virgie;
James Shipp, M. D., Louisville;
Orville A. Zeller, M. D., Pikeville;
Allen F. Zoeller, M. D., Louisville.

Dramamine's® Effect in Vertigo

Dramamine has become accepted in the control of a variety of clinical conditions characterized by vertigo and is recognized as a standard for the management of motion sickness.

Vertigo, according to Swartout, is primarily due* to a disturbance of those organs of the body that are responsible for body balance. When the posture of the head is changed, the gelatinous substance in the semi-circular canals begins to flow. This flow initiates neural impulses which are transmitted to the vestibular nuclei. From this point impulses are sent to different parts of the body to cause the symptom complex of vertigo.

Some impulses reach the eye muscles and cause nystagmus; some reach the cerebellum and skeletal muscles and righting of the head results; others activate the emetic center to result in nausea, while still others reach the cerebrum making the person aware of his disturbed equilibrium. *Vertigo may be caused by a disease or abnormal stimuli of any of these tissues involved in the transmission of the vertigo impulse, including the cerebellum and the end organs.*

A possible explanation of Dramamine's action is that it depresses the overstimulated labyrinthine structure of the inner ear. Depression, therefore, takes place at the point at which these impulses, causing vertigo, nausea and similar disturbances, originate. Some investigators have suggested that Dramamine may have an additional sedative effect on the central nervous system.

Repeated clinical studies have established Dramamine as valuable in the control of the symptoms of Ménière's syndrome, the nausea and vomiting of pregnancy, radiation sickness, hypertension vertigo, the vertigo of fenestration procedures, labyrinthitis and vestibular dysfunction associated with antibiotic therapy, as well as in motion sickness.

Any of these conditions in which Dramamine is effective may be classed as "disease or abnormal stimuli"* of the tissues including the end organs (gastrointestinal tract, eyes) and their nerve pathways to the labyrinth.

Dramamine (brand of dimenhydrinate) is supplied in tablets of 50 mg. and liquid (12.5 mg. in each 4 cc.). It is accepted by the Council on Pharmacy and Chemistry of the American Medical Association. G. D. Searle & Co., Research in the Service of Medicine.



The site of Dramamine's action is probably in the labyrinthine structure.

*Swartout, R., III, and Gunther, K.: "Dizziness:" Vertigo and Syncope, GP *8*:35 (Nov.) 1953.

WASHINGTON NEWS DIGEST

Washington, D. C.—While Congress didn't enact all the health bills President Eisenhower's administration wanted to put through, it did mark up an imposing record of accomplishment. In fact it passed more health and medical legislation than any Congress in many, many years. The AMA actively supported most of the bills finally enacted, and opposed none of them.

Four important new laws were written into the statutes before the session ended—expansion of the Hill-Burton hospital construction program, expansion of the vocational rehabilitation program, amendment of the income tax law to allow more liberal deductions for medical expenses, and transfer of the responsibility for health of the Indians to U. S. Public Health Service.

For years a group of state health officers have been working to bring about the transfer of Indian hospital and medical service from the Indian Bureau in the Department of the Interior to Public Health Service in what is now the Department of Health, Education, and Welfare. The health officers could show beyond any question that the Indians were receiving far less medical care than the rest of the population. They maintained that if the Public Health Service were made responsible for the Indians' health, there would be a rapid change for the better on the reservations.

What might be called governmental inertia succeeded in holding up the legislation for a time, but this Congress decided to make a shift. Public Health Service, which will take over on the reservations next July 1, already has plans under way to insure the Indians more and better medical care.

The demands for a more dynamic vocational rehabilitation program have been building up outside the federal government as well as in Washington. The problem facing this administration was to get more people rehabilitated but at the same time to induce the states to take a more active part in the work. The law now enacted promises to do this. It authorizes gradual increases in the federal appropriations, but at the same time is aimed at bringing the states



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up to the position of full financial partners by the end of five years. The goal is to rehabilitate at least 200,000 persons annually, in place of the present 60,000.

If local communities are willing to raise from one-third to one-half of the cost, the new Hill-Burton program should result in the construction, within three years, of possibly a half billion dollars in new facilities—rehabilitation centers, diagnostic-treatment clinics, chronic disease hospitals, and nursing homes. (This program was discussed in detail last month in this space.) The new construction will be in addition to the continuing Hill-Burton grants for complete hospitals.

On the medical cost deduction question, too, economists long have felt that families with unusually large medical expenses should be given more liberal tax deductions. The new law will allow them to deduct medical expenses in excess of three per cent of taxable income. Under the old law the figure was five per cent. A $3,000 income family with $150 in medical expenses under the old law could deduct nothing, but under the new law $60. The Treasury estimates that the total savings to families will be $80 million.

The general public probably read and heard more about the one bill that was defeated—reinsurance—than it did about all the health and medical legislation that passed. That defeat (in the House) was a surprise and a disappointment to the President. His advisors might have told him that all was not well, but obviously they did not. Opposition was not confined to the AMA. Also lined up against it were most of the health insurance companies, the U. S. Chamber of Commerce and a number of other professional groups. The labor unions would accept it, but wouldn't work to get it. Most significant of all, it had lukewarm support at best from the lawmakers who know most about it, the Senate and House committees that conducted the hearings.

SMA to Meet Nov. 8-11

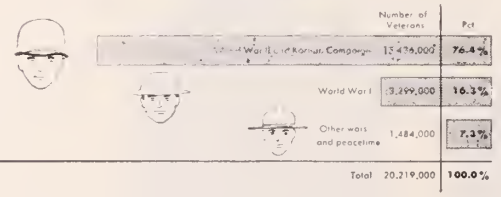
Months of careful planning and preparation for the 1954 Annual Meeting of the Southern Medical Association to be held in St. Louis, November 8-11, have resulted in a most profitable and worthwhile program, according to Alphonse McMahon, M.D., St. Louis, president.

The twenty-one sections will meet in half-day sessions beginning Monday afternoon and extending through Thursday forenoon. The plan of the meeting will be the same as that carried out for the past three years. Festive highlights include an Association dinner to be held Wednesday night and "The Doctor's Day Luncheon" sponsored by the Auxiliary to be held Tuesday.

In Viewing the VA Medical Program . . .

analysis of veteran population

PERIOD OF SERVICE



Taxpayers should note that as veterans grow older they require more frequent and increasingly longer periods of hospitalization. World War I patients are now hospitalized twice as long, on the average, as World War II patients with similar disabilities. World War II veterans, relatively young and comprising 76% of the total veteran population, present a costly long term responsibility to U. S. taxpayers. The medical profession recommends medical care through the VA for only those veterans with service-incurred disabilities and temporarily for those with tuberculosis or neuropsychiatric conditions of non-service-connected origin.

In Viewing the VA Medical Program . . .

analysis of present veteran population

AGE DISTRIBUTION (Exclusive of those discharged on or after June 27, 1950)

DATE	JAN. 1, 1952	JAN. 1, 1960	JAN. 1, 1970
TOTAL	18,850,000	18,160,000	16,146,000
AGE 22-44	77.2%	62.7%	13.5%
45-64	21.8%	27.4%	73.7%
OVER 65	1.0%	9.9%	12.8%

Older veterans are hospitalized more frequently for civilian-incurred ailments than for service-connected disabilities. By 1970, over 86% of the present veterans will be age 45 or over, more than three times the number in this older age group today. Because of advanced age, they will require more frequent and prolonged hospitalization for illnesses having no relationship to their military service. Responsibility for such medical care should be assumed by the individual or local government, not by the federal government.

ANESTHESIA FOR WOUNDED MEN

(Continued from page 674)

tion should be avoided when the operative position or procedure may interfere with the airway or make artificial respiration difficult, as in operations that must be carried out with the patient in the face-down position and in operations on maxillofacial injuries or other injuries involving the airway. If local anesthesia is inadequate (as usually will be the case here), use ether, preferably with endotracheal intubation.

(b) Although skillful (or lucky) men may often "get away" with the use of thiopental (Pentothal(R)) sodium as the chief anesthetic agent for intracranial surgery, its employment is usually not wise for the following reasons: such operations are long. Thiopental anesthesia is best limited to short (half-hour) procedures. Intracranial operations are usually associated with great blood loss, often a liter or more by actual measurement. Extensive blood loss contraindicates use of thiopental. However, when the blood loss is not great, thiopental may be used as an adjunct to local anesthesia, as a sleep-producing agent rather than as an anesthetic. The drug sometimes unexpectedly causes respiratory depression and anoxia. Anoxia produces immediate swelling of the brain and may make an intracranial procedure difficult or impossible. In these cases local anesthesia or ether are the best available choices for wounded men.

(c) Experience shows that patients with severe burns tolerate thiopental anesthesia poorly.

The great field of trauma in which thiopental (Pentothal(R)) sodium has proved its value is in providing anesthesia, when relaxation is not needed, for short (half-hour) procedures in men in good condition, with slight wounds and little blood loss. Supplementation of thiopental with 50 per cent nitrous oxide anesthesia and 50 per cent oxygen is often desirable. (see comments above on the importance of emptying the stomach of the patient before thiopental anesthesia is induced.)

Summary

The early care of the seriously wounded man has been summarized from the moment of wounding until the surgeon repairs the wound. This has been stated first in terms of general principles and then in terms of specific procedures.

News Items

John M. Baird, M. D., recently opened an office in Danville. Dr .Baird is a 1953 graduate of the University of Louisville School of Medicine and interned at St. Elizabeth Hospital, Dayton, Ohio.

Charles W. Sisk, M. D., has located in Danville and will do general practice. A 1953 graduate of the University of Louisville School of Medicine, Dr. Sisk interned at St. Elizabeth Hospital, Dayton, Ohio.

Samuel R. Scheen, Jr., M.D., began practicing recently in Cloverport, in Breckinridge county. Dr. Scheen received his medical degree from the University of Louisville School of Medicine in 1953 and interned the past year at St. Joseph Infirmary, Louisville.

William B. Hamilton, M. D., has located in Shepherdsville, in Bullitt county. Dr. Hamilton was graduated from the University of Louisville School of Medicine in 1953 and interned at St. Elizabeth Hospital, Dayton. He was born in 1922.

George M. Gumbert, Jr., M. D., a graduate of the University of Louisville School of Medicine in 1953, has located in Olive Hill, in Carter county. Dr. Gumbert served his internship at General Hospital, Washington, D. C.

Benjamin P. Smith, Jr., M. D., has located in Owensboro for the practice of general medicine. Dr. Smith, who was born in 1924, received his medical education at the University of Louisville School of Medicine. He graduated in 1953 and interned at Louisville General Hospital.

George F. Harris, M. D., who received his medical degree from the University of Louisville School of Medicine in 1953, recently located at Warsaw, in Gallatin county. Dr. Harris interned at St. Elizabeth Hospital, Covington.

David E. Lewis, M. D., after finishing his internship at St. Joseph Infirmary, Louisville, has located at Elizabethtown. Dr. Lewis graduated from the University of Louisville School of Medicine in 1953. He was born in 1928

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Ben W. Crawford, M. D., has located in Cumberland, in Harlan county. He is a 1953 graduate of the University of Louisville School of Medicine and interned at the Good Samaritan Hospital, Lexington.

Dewey E. Cummins, M. D., a 1953 graduate of the University of Louisville School of Medicine, has located in Nicholasville, in Jessamine county. Dr. Cummins interned at the Good Samaritan Hospital, Lexington.

John R. Stevie, M. D., recently opened an office in Covington. Dr. Stevie was graduated from the University of Louisville School of Medicine in 1953 and interned at St. Elizabeth Hospital, Covington.

George Estill, M. D., a native of Mayslick, associated with **Mitchell Denham, M. D.,** and **Harry Denham, M. D.,** on July 15, 1954, in Maysville. A graduate of the Georgetown University School of Medicine, Washington, D. C., in 1952, Dr. Estill interned at Emergency Hospital, Washington, D. C. He took a residency in internal medicine at the Veterans Administration Hospital, Washington D. C.

Charles J. Shipp, M. D., after finishing his internship at St. Joseph Infirmary, Louisville, has located in Greenville. Dr. Shipp received his medical education at the University of Louisville School of Medicine. He was graduated in 1953.

Martha W. Harmon, M. D., has located in Louisville after finishing an internship at Louisville General Hospital. Dr. Harmon received her medical education at the University of Louisville School of Medicine, graduating in 1953.

Houston Hedges, Jr., M. D., recently opened an office in St. Matthews to do general practice. He is a 1953 graduate of the University of Louisville School of Medicine and interned at St. Joseph Infirmary, Louisville.

James W. Davis, M. D., resumed his medical practice in Louisville during the month of July after spending 18 months in the United States Air Force. Dr. Davis was graduated from Creighton University School of Medicine, Omaha, Nebraska, in 1949, and interned at St. Joseph Infirmary. He is a native Kentuckian.

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Jack K. Hellmann, M. D., associated with C. **E. Quaife, Jr., M. D.,** in Louisville July 1, 1954. Dr. Hellmann, who is a 1953 graduate of the University of Louisville School of Medicine, interned at St. Joseph Infirmary, Louisville.

Stuart M. Hunter, M. D., recently took over the practice of J. O. Knight, M. D., Louisville, who died earlier this year. Dr. Hunter interned at General Hospital, Greenville, South Carolina. He was graduated from the University of Louisville School of Medicine in 1953.

James F. Shipp, M. D., opened an office in Louisville to do general practice. Dr. Shipp interned on the West Coast at Los Angeles County Hospital after graduating from the University of Louisville School of Medicine in 1953.

Buster F. Brown, M. D., after finishing his internship at the Kentucky Baptist Hospital, Louisville, located in Harrodsburg, in Mercer county. Dr. Brown, who was born in 1927, was graduated from the University of Louisville School of Medicine in 1953.

Robert L. McKenney, M. D., a 1953 graduate of the University of Louisville School of Medicine, has located in Falmouth to do general practice. Dr. McKenney interned at the Good Samaritan Hospital, Lexington.

Grover B. Sanders, M. D., has announced his association with **W. Reeve Hansen, M. D.,** and **Robert L. McClendon, M. D.,** of Louisville, for the practice of internal medicine. Dr. Sanders was the Assistant to the Chief of Medical Services and Assistant Chief of the Section of Chest Diseases at the Veterans Administration Hospital, Louisville, from July, 1952—July, 1 54. He was graduated from the University of Louisville School of Medicine in 1945 and interned at the U. S. Naval Hospital, Portsmouth, Virginia. Dr. Sanders has taken two residencies in internal medicine at the VA Hospital in Louisville. During World War II, he served three years with the United States Navy.

Charles R. Fisher, M. D., a native of Ohio county, opened an office July 26, 1954, in Flemingsburg. Dr. Fisher was graduated from the University of Louisville in 1953 and interned at Louisville General Hospital.

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Robert A. Clary, M. D., has located at Guthrie after finishing an internship at St. Elizabeth Hospital, Dayton, Ohio. Dr. Clary was graduated in 1953 from the University of Louisville School of Medicine.

S. Pearson Auerbach, M. D., recently announced the opening of his office in Louisville for the practice of orthopedic surgery. Dr. Auerbach was graduated from the University of Louisville School of Medicine in 1949 and interned at Louisville General Hospital. He took a residency in general surgery at the Veterans Administration Hospital, Louisville, from 1950-51, and a two year residency there in orthopedic surgery from 1951-53. He received additional orthopedic training at Kosair Crippled Children's Hospital from 1953-54.

Millard A. Shepherd, M. D., recently located in Harrodsburg. Dr. Shepherd received his medical degree from the University of Louisville School of Medicine in 1953 and interned at the Kentucky Baptist Hospital, Louisville.

SPECIAL ARTICLE

(Continued from page 689)

up anyway. You must establish a bridge between what you are discussing, and the audiences every day life.

Third, for instance. During the course of the speech, get down to specific cases. Cite examples. Remember that a doctor has at hand a very effective "for instance" that no one else has. All he has to do to stimulate audience interest is to say, "today in my office I saw a very interesting thing" or he may say "yesterday in the operating room an unusual thing happened." This can be done without personal advertising.

In the fourth step answer the, "so what." Ask for action. Tell the audience what you want them to do about this thing you have discussed. Ask the audience for some specific action which is within their power to give.

And above all things keep contact with your audience. Look as many of them in

the eye as possible. Let them feel that they are directly influencing what you say.

I see that I have used up more than my time so that if I am to follow my own advice I must conclude with a, so what. It is simply this. Let us not forget that physicians who give their time and effort to a speakers bureau should receive all possible credit for extending and cementing a feeling of good will between groups. They are helping to perpetuate a real basic understanding of the role of organized medicine and to gain more supporters for the future. If any one is ever fool enough to ask you to speak, be wise enough to speak. I thank you.

A polio victim who has had his tonsils removed is about four times more likely to have the serious bulbar type of polio than a patient who still has his tonsils, it was reported in the Journal of the AMA. This finding was made after a study of more than 2,000 victims of a 1946 polio outbreak in Minnesota.

The Hektoen Gold Medal, the highest honor of the American Medical Association for scientific exhibits, was awarded to the Veterans Administration during the AMA meeting in San Francisco. The exhibit depicted the scope of work being done at Houston, Texas, in connection with the diagnosis and surgical treatment of the diseased aorta and its main branches.

The 1954 Annual Convention of the National Society for Crippled Children and Adults will be held November 3-5, 1954, at the Hotel Statler, Boston, Massachusetts. The meeting will bring together authorities in all fields of work relating to the rehabilitation of crippled children and adults.

"A Citizen Participates," a popular AMA film has won top honors as an educational motion picture at the Cleveland Film Festival and was chosen by Scholastic Teacher for a National Film Award. The film describes how a small town in need of a physician goes about getting one, and can be booked through the AMA's Film Library.

The Board of Trustees have established a new department within the AMA which is known as the Law Department. Effective since August 1, the new department replaces the Bureau of Legal Medicine and Legislation and will be headed by C. Joseph Stetler, secretary of the AMA Council on National Emergency Medical Service since 1951.

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In Memoriam

JOHN A. MAHAFFEY, M. D.

Richmond

1886 - 1954

John A. Mahaffey, M. D., who had practiced in Richmond since 1918, died suddenly on July 15 at the Pattie A. Clay Infirmary. Aside from his practice in Madison county, Dr. Mahaffey spent 61 years of his medical service in Owsley, Lee, Breathitt, Perry, Leslie, Clay, Jackson, Laurel and Estill counties.



Dr. Mahaffey

Dr. Mahaffey was born at Sturgeon, in Owsley county. He attended Berea College and was graduated from the Hospital College of Medicine, Louisville, in 1893, with second honors for excellence in all branches.

He was the father of Hugh Mahaffey, M. D., Richmond, councilor for the Eleventh District of the KSMA, and Herman Mahaffey, M. D., Louisville. Dr. John Mahaffey was a staff member of the Pattie A. Clay Infirmary, Richmond, and a former president of the Madison County Medical Society. He was a member of the KSMA and AMA.

In 1912, The Rockefeller Foundation offered to give $20,000 a year for control of hookworm in Kentucky if its prevalence could be proven. Dr. Mahaffey was one of the physicians who helped obtain specimens from 1,000 people in Owsley county. The results of the project brought about the granting of the sum.

Before the day of the automobile, Dr. Mahaffey made rural visits on horseback and many times had to make use of kitchen tables for operations. Frequently he relied on kerosene lamps for light while performing delicate operations.

The American Medical Association in a joint endeavor with the American Hospital Association, held a reception in August for "the angel of Dien Bien Phu," Mlle. Genevieve de Galard-Terraube. The gallant French nurse, who entered the United States by Congressional invitation, cooperated with various allied health organizations in helping to emphasize a nurse recruitment program.

HENRY HALL TRIPLETT, M.D.

Corbin

1906 - 1954

Dr. Henry Hall Triplett, of Corbin, died June 27, 1954, at Barnes Hospital, St. Louis, following an operation. Dr. Triplett had been in ill health for several years. He was forty-seven years of age.

Dr. Triplett was graduated from the University of Tennessee College of Medicine in 1933. He was a member emeritus of the Kentucky State Medical Association.

JOHN R. SHACKLETTE, M. D.

Jeffersontown

1888 - 1954

Dr. John R. Shacklette, 66, died July 31, 1954, at Fond du Lac, Wisconsin hospital. He retired seven years ago and had been ill with a heart ailment for 10 months.

He was graduated from the University of Louisville School of Medicine in 1912 and served in the United States Army during World War I. He held the rank of Major.

During the earlier part of his 35 year medical



career, Dr. Shacklette visited his patients by horseback in the Jeffersontown area. He became president of the Jeffersontown Bank and was a member of the Town's Board of Trustees for a number of years.

He held membership in the Jefferson County Medical Society, the Kentucky State Medical Association and the American Medical Association.

STUART GRAVES, M. D.

Louisville

1882 - 1954

Dr. Stuart Graves died July 14, 1954, following a heart attack at Blowing Rock, North Carolina, where he was spending a vacation. Dr. Graves, 72, was a former dean of the University of Louisville School of Medicine from 1922 to 1928 when he resigned to take a similar position at the University of Alabama. He retired from that post in 1947.

Dr. Graves came to Louisville in 1914. In 1918 he became an acting assistant surgeon for the United States Public Health Service in Louisville. He was a native of Boonville, New York.

He attended Syracuse University and trained in pathology at the Boston City Hospital. Dr. Graves held various offices in the Southern Medical Association. He was a fellow of the American College of Physicians and of the American Association of Pathologists and Bacteriologists. Dr. Graves returned to Louisville last year from Tuscaloosa, Alabama.

JOHN EDWARDS KINCHELOE, M.D.

Hardinsburg

1878 - 1954

Dr. John Edwards Kincheloe died June 25, 1954, following a heart attack, in Breckinridge Memorial Hospital, an institution he helped found. A native of Hardinsburg, he had practiced there since 1900 after his graduation from the old Kentucky School of Medicine in Louisville in 1899.

In 1946 Dr. Kincheloe received the E. M. Howard Medal from the Kentucky State Medical Association for outstanding service in behalf of organized medicine. The same year, some 5,000 persons, many of them "Kincheloe babies," paid tribute to him on a special "Doctor Kincheloe Day."

At the time of his death, Dr. Kincheloe, who was 76 years of age, was secretary of the Breckinridge County Medical Society. He held membership in the American Medical Association.

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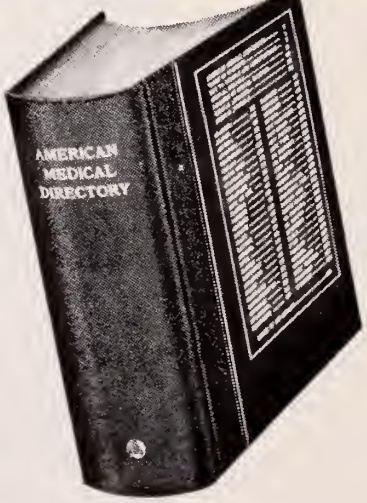
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JOSEPH W. NOLAN, M.D.

Harlan

1880 - 1954

Dr. Joseph W. Nolan died June 17, 1954, at Veterans' Hospital, Mountain Home, Tennessee, after a long illness. He had practiced in Harlan since 1915 until failing health forced his retirement a few years ago.

Dr. Nolan was born in Chad, in Harlan County, and was graduated from the Louisville Hospital College of Medicine in 1904. He later studied at the University of Berlin and the University of Vienna.

In June of 1904 he established a medical practice in Korea where he remained for 11 years before returning to Harlan. Dr. Nolan specialized in eye, ear, nose and throat.

J. SAM BROWN, M.D.

Ghent

1871 - 1954

Dr. J. Sam Brown, 83, died at his home in Ghent, July 2, 1954. He had practiced in Carroll and surrounding counties for almost 60 years starting at the age of 20.

Dr. Brown was a recipient of the Kentucky State Medical Association's Distinguished Service Medal in 1948. He was graduated from the Medical Department of the University of Louisville in 1892 and began practice in Ghent with his father, the late M. C. Brown, M.D.

For several years he was chairman of the Tri-County Health Board of Gallatin, Trimble, and Carroll counties. He was an active member of the American Medical Association.

JAMES S. LUTZ, M. D.

Louisville

1878 - 1954

Dr. James S. Lutz, 76, died July 13, 1954, at St. Joseph Infirmary in Louisville. He had been in the hospital since the latter part of June.

Since 1905, Dr. Lutz had practiced in Louisville. He was graduated from the the Medical Department of Kentucky University in 1905. He was a member of the Army Medical Corps during World War I, and was discharged as a captain.

A native of Charlestown, Indiana, Dr. Lutz was a member of the American, Southern and Kentucky Medical Associations. He was prominent in church and civic affairs of his community.

County Society Reports

CALLOWAY

Members voted to support nutritional classes for expectant mothers and small children at the monthly meeting of the Calloway County Medical Society, July 6, held in the Chapel of the Murray Hospital.

The classes are to be held at the Health Center under the direction of Miss Murphy, State Department of Health worker. Acceptance for application to these classes must have the physicians' approval.

C. C. Lowry, M. D., president, called the meeting to order. Other physicians present included: A. D. Butterworth, Hugh Houston, C. H. Jones, O. K. Mason, J. A. Outland, John Quertermous, Kenneth Ross, Charles Tuttle, Birdsall Carle, David S. Colvin and Lad R. Mezera.

C. C. Lowry, M. D., President
J. L. Hopson, M. D., Secretary

SCOTT

The Scott County Medical Society held its one hundred and twenty third consecutive monthly meeting, August 5, at the John Graves Ford Memorial Hospital in Georgetown.

The Secretary read a letter from Mr. Joe Sanford, executive secretary of the Kentucky State Medical Association, saying that Mr. John Guy Miller, field secretary, would put on a program at the next meeting.

Dr. Wells reported a case of ruptured extrauterine pregnancy and severe secondary hemorrhage. After a full discussion the meeting adjourned.

H. V. Johnson, M. D., Secretary

WILLINGNESS TO SERVE

(Continued from page 692)

travel an average total of 1,000 miles per meeting.

In conclusion, Doctor Cox comments quite forthrightly as follows:

"You may feel and even say that your Association is run by groups or cliques, and that you have no chance to assist. If such is your feeling, it is time for some self-examination. Have you attended your County Meetings regularly? Have you honestly exerted yourself when put on a committee? Have your efforts been unselfish and unbiased? By conscientious, zealous, unselfish activity in your Society, I daresay in a few years you, too, will belong to the "clique" running your Association. It is high time that we all exert ourselves on a united front if we are to forestall the inroads of Socialism."

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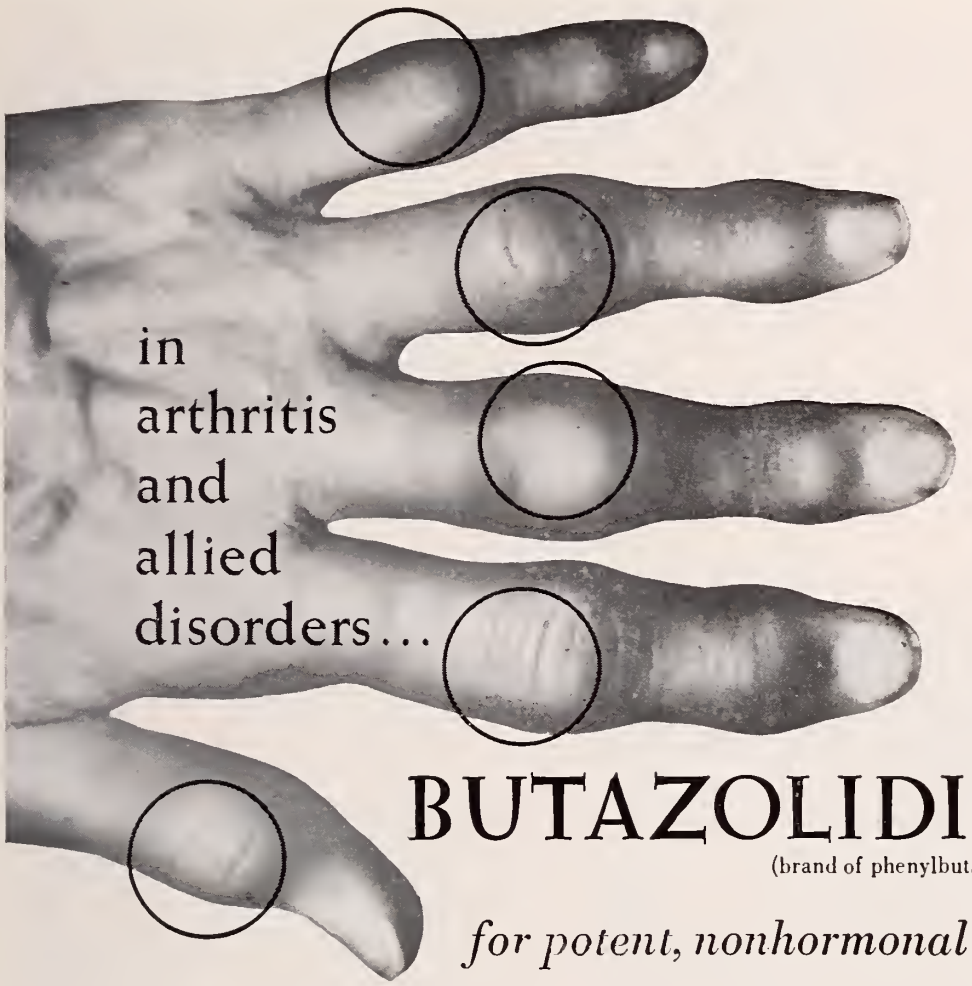
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**Heck, W.E.; Lynch, W.J., and Graves, H.L.: Acta oto-laryng. 43:416, 1953.*

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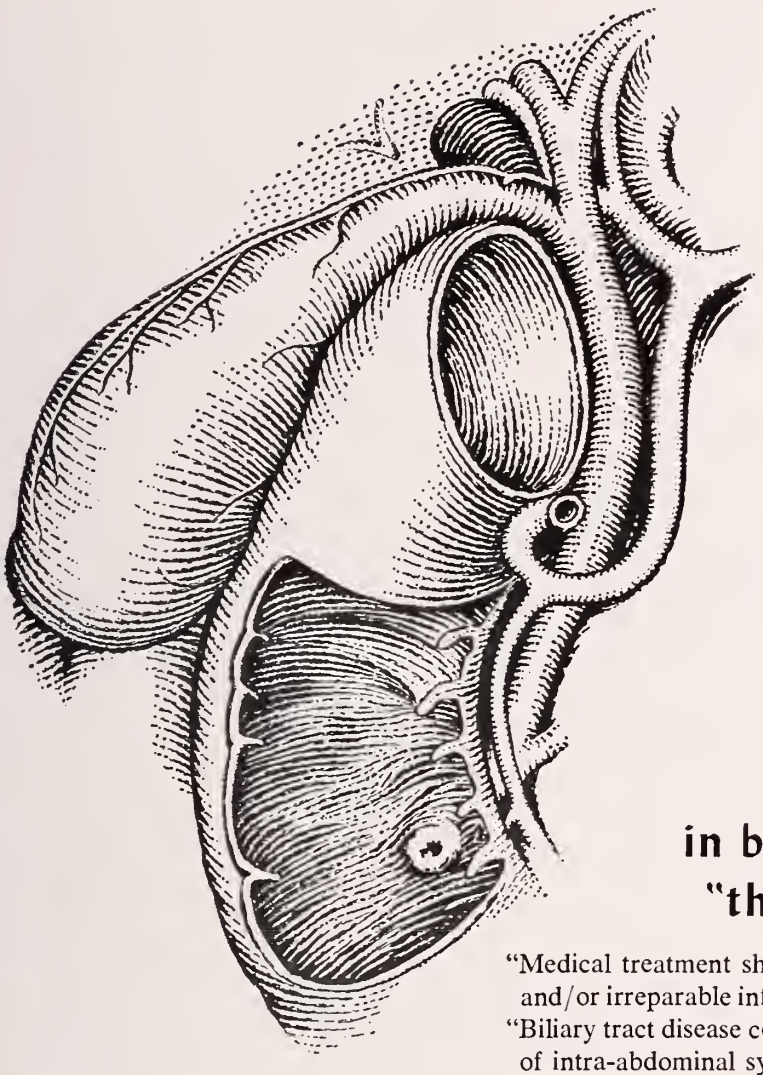
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1. Segal, H.: Postgrad. Med. *13*:81, 1953. 2. O'Brien, G. F., and Schweitzer, I. L.: M. Clin. North America *37*:155, 1953. 3. Beckman, H.: Pharmacology in Clinical Practice, Philadelphia, W. B. Saunders Company, 1952, p. 361.

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*Kaufman, R. H.; Mendelowitz, S. M., & Ratzan, W. J.: *Am. J. Obst. & Gynec.* 65:269, 1953.

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References: 1. Hollander, F.: Arch. Int. Med. *93:*107 (Jan.) 1954
2. Deutsch, E.: Scientific Exhibit, Gastroscopy, Interim Session A.M.A., St. Louis, December, 1953

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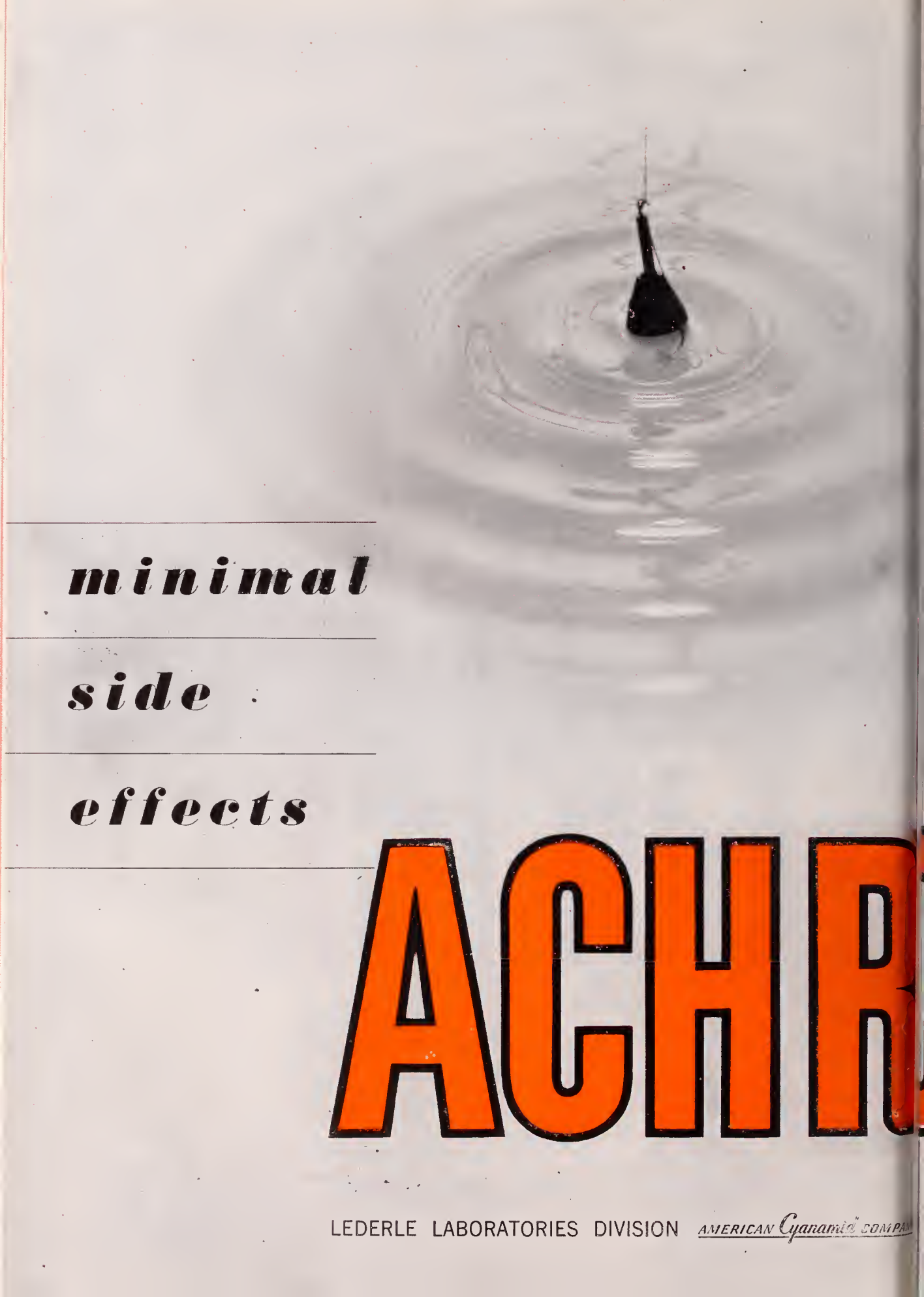
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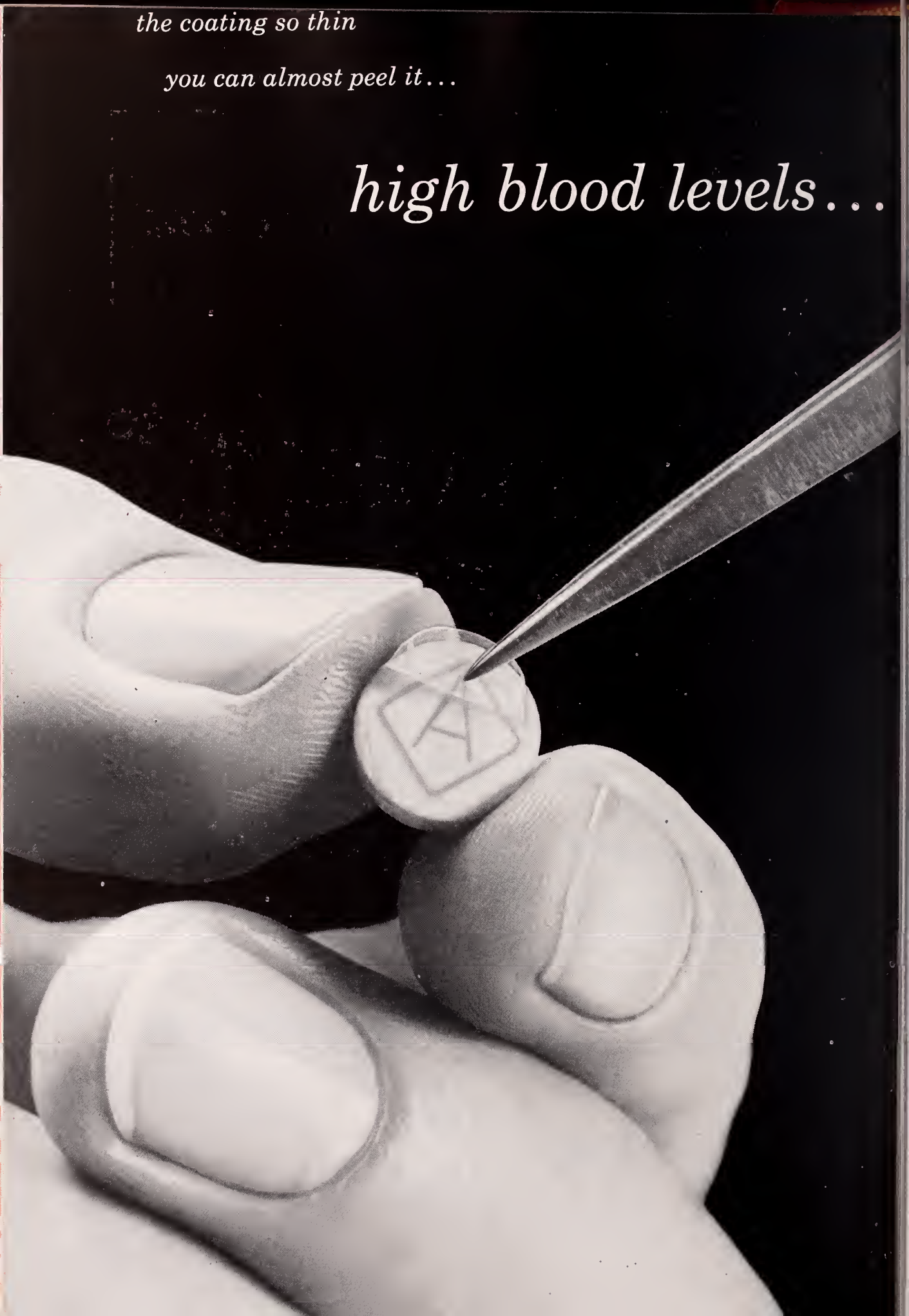
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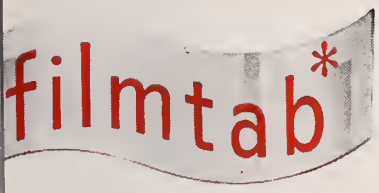
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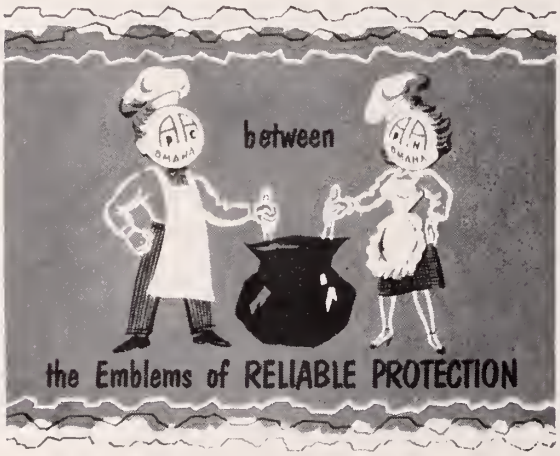
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1. Greenblatt, R. B., and Kupperman, H. S.: M. Clin. North America *30*:576 (May) 1946. 2. McGavack, T. H., in Goldzieher, M. A., and Goldzieher, J. W.: Endocrine Treatment in General Practice, New York, Springer Publishing Company, Inc., 1953, p. 225.

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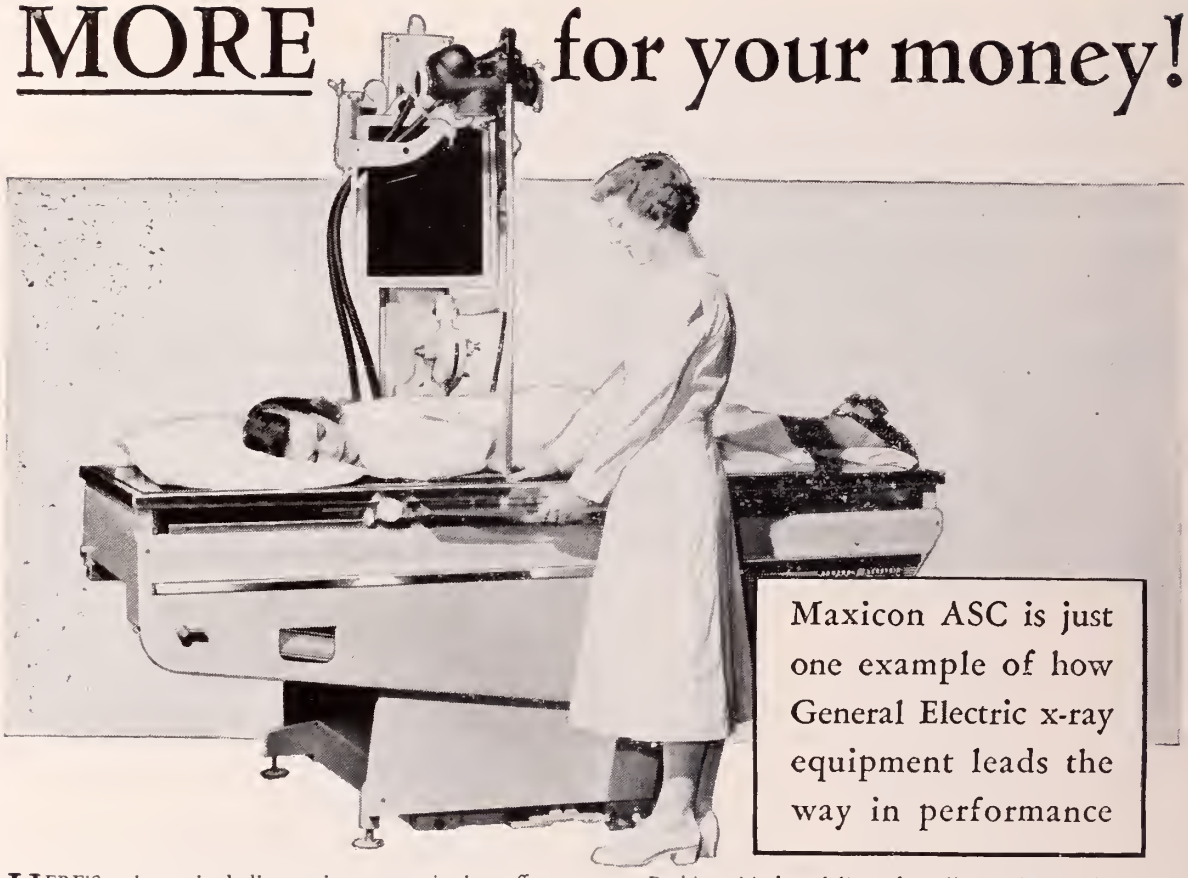
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The Complications of Varicose Veins*

DAVID WOOLFOLK BARROW, M. D.
Lexington

The major complications of varicose veins are phlebitis and ulceration. These are well illustrated by the four case reports presented here.

The first of these patients was reported in the "Annals of Surgery."

Pulmonary Embolism

A white female, aged 49, complained of pain in the left leg of eleven days duration, which, initiated in the calf following a blow, had extended to the groin. This distress was intensified by walking and the patient said she had had five slight chills prior to admission.

Twenty-eight years before admission, soon after the birth of a child, the patient had tremendous swelling and discomfort in her left leg of sudden onset. A diagnosis of phlegmasia alba dolens (milk leg) was made. Her discomfort was relieved by rest in bed, but since that time, the patient had noticed dilated, tortuous superficial veins of the left leg, which became larger progressively. Several years prior to admission, subcutaneous rupture of one of the varices resulted in localized pain and a residual hematoma which was absorbed slowly. There had been no ulceration of the leg. Five years before entry, the patient had a cholecystectomy and incidental appendectomy without post-operative complication. She had had whooping cough, chicken pox, measles, malaria and rheumatic fever in childhood.

On physical examination, the patient was obese. She was able to walk, but reluctant to do so because of aggravation of pain in her left leg. There were multiple, tender, nodular, cord-like swellings along the course of both the long and short saphenous veins. The left calf was slightly larger than the right, and the subcutaneous tissues were indurated. There was no detectable difference in temperature on the two sides. The dorsalis pedis arteries on both sides were readily palpable. The blood pressure was 150/90 and the pulse on admission 103 varying from 80 to 110 during her hospital stay. Her temperature was 97.7° F on admission and varied between 97° F and 100° F. The initial white count was 14,500 and the urine negative.

A diagnosis of superficial thrombo-phlebitis in pre-existing varicose veins was made and ligation of the saphenous vein was proposed but refused by the patient. The symptoms subsided rapidly on conservative treatment. And, although the patient was anxious to go home, she was kept in bed since extensive localized tenderness remained.

On the fourteenth hospital day at 5:30 A.M., the patient experienced sudden pain under the sternum immediately after exerting herself to get on the bed pan. This pain was followed by profuse sweating, dyspnea, cyanosis and death in a very few minutes.

Autopsy—The superficial veins of the leg were irregularly distended and contained firm clots. These did not extend into the deep veins. On microscopic examination, the clots were found to be partially organized. The lungs were reddish-purple in color, boggy in consistency and weighed 1,310 gms. On section, the entire parenchyma was edematous. The bronchial tree and hilar lymph nodes were normal. A loose fitting thrombus filled the pulmonary artery and extended into the left main branch. The inferior vena cava, portal vein, iliac vein and femoral vein

*Read before the First Councillor District Meeting, Paducah, April 28th, 1954.

contained no thrombi. The pathologist on the basis of his examination, felt that the pulmonary embolus arose from the left great saphenous vein.

Such accidents are not common, yet five tenths of one percent of all fatal pulmonary emboli arose from superficial veins according to Nobl, all of which can be prevented by ligation of the long saphenous vein and its branches, at the sapheno-femoral junction. (Fig. I.) I consider superficial thrombophlebitis to be more of an emergency than acute appendicitis for I would rather have a ruptured appendix than a pulmonary embolism. Following ligation, residual discomfort may be controlled by immobilization with elastic adhesive plaster, although very large thrombotic areas may require excision.



Figure I—Thrombophlebitis in superficial vein of sufficient size to completely occlude the pulmonary artery.

Ulceration

A second report is that of Mrs. L. R., a thirty-six year old white married housewife who had had bilateral, deep thrombophlebitis following the birth of her first child eighteen years before, and again following the birth of her second child two years later. Dependent edema did not subside completely and within eight months, she had a tender indurated area proximal to the medial malleolus. This improved with bed rest, but recurred promptly upon getting up. On two occasions, the ulcer and underlying tissues were excised, and the defect covered with a skin graft. Ulceration recurred within eight months each time. Elastic stockings had been helpful, but it was still necessary for the patient to limit her activity sharply and spend a large portion of each day in bed.

Physical examination showed a moderately obese white female with a painful ulceration just above the medial malleolus, surrounded by pigmented scarring. A linear scar extended from the ulcer to just below the knee. There were no visible varices of any kind but there was increased tension in the veins of the leg which could be appreciated by palpation, immediately upon standing with the three tourniquets in place.

Since we feel that the disability in patients with varicose veins is largely due to abnormal accumulations of interstitial fluid or edema, we were interested in measuring the increase in volume of the leg of this patient upon standing. Fluid accumulated at more than ten times the normal rate.

Ligation of both superficial femoral veins was done with symptomatic relief and eight weeks after ligation of the superficial femoral vein, the increase in volume on standing was again measured.

At that time, we found the initial volume of the leg with the patient standing:

	3975 cc's+
5 Minutes later	40 cc's+
10 Minutes later	50 cc's+
15 Minutes later	65 cc's+
20 Minutes later	85 cc's+
25 Minutes later	90 cc's+
30 Minutes later	110 cc's+

This is approximately normal. A year later, there was some increase in this rate but in no way comparable to the preoperative rate. The patient was asymptomatic, but continued to wear tight elastic bandages, and has been able to lead a normal life since that time.

Adequate evaluation of the role of ligation of the superficial femoral vein in patients with extensive varicose veins, is not yet available. It is known that organization of the intra-vascular clot in patients with thrombophlebitis per se, destroys the valves in the involved segment and renders the vein incompetent or varicose. If the vein so afflicted is a superficial one, superficial varicose veins result, but if the deep veins are involved as they are in phlegmasia alba dolens or milk leg, deep valves are destroyed and the segment of deep vein so involved becomes useless. Fortunately in slightly more than half (54.5%) of the patients with deep thrombophlebitis, the segment involved is short and distal valves compensate for the ones destroyed. In the remaining patients, however, there is venous hypertension thruout the deep veins, with dilation and incompetence of the veins communicating between the deep and superficial veins

in the leg. Fatigue, swelling and ulceration are common and treatment arduous.

The problem in these patients is the prevention of edema. The simplest way to do this, is by external elastic pressure; elastic bandages, or stockings, or an Unna's paste boot. Where superficial veins are also incompetent, these should be removed. If these measures do not prove adequate, ligation of the superficial or the popliteal vein is indicated, selected on the basis of an abnormally rapid accumulation of fluid on standing as in this patient. Lumbar sympathectomy was not done here but in a very rare patient, vasospasm persists for many years following deep thrombophlebitis. In these patients lumbar sympathectomy is helpful. Their number is small. Sympathectomy may also be useful in patients who have hyperhidrosis and eczema; but let me repeat, the number is small.

Painful Ulceration

The third case report is that of a patient with a very painful ulcer. Mrs. K. S., a 42 year old white elevator operator, had had an ulcer of the left leg for three years. She had had deep thrombophlebitis twelve years before, from which she had apparently recovered promptly. A few months later, she noticed enlarged veins of the left leg which had increased in size progressively. She noticed that her left leg began to swell at the end of day, a year or two after her phlebitis. Control by an elastic stocking became less successful as time went on. Three years before entry, she struck her leg and it refused to heal.

The patient had to continue to work and the ulcer had become larger and the pain almost unendurable.

Abnormal physical findings were limited to a well healed mid-line scar from a previous hysterectomy and a swollen left leg with a dirty-ragged ulcer ten centimeters in diameter just proximal to the ankle and, indurated, inflamed subcutaneous tissues to the knee. (Fig. II.) The long saphenous vein filled rapidly upon release of a tourniquet around the thigh when the patient stood. It was probable that there were incompetent communicating veins in the leg as well, but this could not be determined on account of the swelling.

Hospitalization was advised since there was so much painful infection in and around the ulcer. This subsided with rest, elevation and hot packs. The ulcerated area was skin grafted and the long saphenous vein removed with a stripper. The patient returned to work fourteen days after admission to the hospital.

A tight elastic bandage reinforced with sponge rubber over the previous ulcer was worn until the grafted skin became tough. Relief from work with elevation of the limbs for fifteen minutes every two hours was insisted upon for two months. Postural exercises were advised and carried out faithfully by the patient.

She has been seen at intervals since her operation in August 1946 and has remained well without loss of time from work. (Fig. III.) There is some incompetence of the communicating veins which has been controlled with elastic bandages, with sponge rubber added when needed. Further surgery is not contemplated as long as external elastic compression is sufficient to control her edema.

Recurrence

The last patient whose history I would like to recount is Mrs. C. R. C., a twenty year old white married para II, who complained of extensive recurrent varices of



Figure II—Inflamed indurated ulcer before treatment.



Figure III—Ulcer healed following skin grafting. Notice the coarse hair which so many patients with leg ulcers develop.

one year's duration. Four years before admission, she had noticed a few dilated veins on each leg. There was reflux of blood on release of the tourniquet in the groin and an operation was performed in the groin on each side. A course of injections followed and the patient was relieved temporarily. During her pregnancy two years later, there was extensive recurrence. A second operation was done in each groin, followed by injection treatment with some improvement. Complete recurrence followed rapidly, however, and at the termination of her second pregnancy, she had severe distress in both legs with large visible varices. There had been no phlebitis and no ulceration.

On examination the multiple tourniquet test showed incompetence of both short saphenous veins and rapid reflux in the region of the sapheno-femoral junction on each side despite the two previous operations in this area. Operation was again advised and accepted by the patient.

The short saphenous veins were indentified and easily removed subcutaneously but there was much scarring and many thin walled collaterals in the groin so that indentification of the long saphenous was impossible until a stripper was introduced into the vein at the ankle and threaded up to the groin where it could be palpated. It lay medial and deep to the mass of scar tissue surrounding the lateral femoral cutaneous vein which had apparently been ligated instead of the long saphenous. The lateral femoral cutaneous vein ordinarily arises as a branch of the long saphenous about 6 cm. from the sapheno-femoral junction but varies. When it arises at or near the sapheno-femoral junction, it is readily mistaken for the long saphenous as it was in this instance. Since the long saphenous had not been ligated at the two previous operations done elsewhere, one could not expect a successful outcome. Such errors in surgical technique are not too common, but the long saphenous is subject to many anatomical variations, and its ligation occasionally requires meticulous, patient dissection. In fact, in 362 patients with varicose veins whom I examined in a follow up study made with Dr. H. H. Faxon at the Massachusetts General Hospital, the most frequent cause of recurrence, was failure to ligate the long saphenous vein or one of its branches at the sapheno-femoral junction. Familiarity with the anatomy of this area and persistence in searching for and recognizing anomalies at the sapheno-femoral junction, is a sine qua non for successful care of these patients.

Conclusion

In conclusion, I would like to remark that varicose veins is a common disease which though disabling is practically never fatal and which, with care on the part of the surgeon and co-operation on the part of the patient, can be controlled and the patient restored to almost complete activity. (Fig. IV & V.) In the more than three thousand patients with varicose veins whom I have seen, I know of only one who was permanently though partially, incapacitated. He was, of course, a physician. One patient died of fulminating sepsis in 1936. Recurrence will occur or new varices develop in less than twenty per cent without further attention. Persistent follow up and continuing care usually of a minor nature will allow every patient to live comfortably and usefully.



Figure IV.—Extensive varices before treatment.



Figure V—Preceding patient following treatment.

Prevention and Treatment of Toxemia of Pregnancy*

STANLEY T. GARBER, M. D.**

Cincinnati

Toxemia of pregnancy is a disease peculiar to pregnant women, characterized by hypertension, edema and albuminuria. The cause is still a matter of speculation. It usually appears after the 24th week of gestation. Six to ten percent of all pregnant women exhibit some form of hypertension.

The purpose of this paper is to give a few practical suggestions in the prevention and management of toxemia of pregnancy. The ultimate aim of any form of treatment is prevention. We believe that toxemia of pregnancy, excluding the patients with underlying hypertension, is a preventable disorder in most instances. Outlined here are a few measures which we have found most helpful. The management resolves itself into three main categories.

I. Preventive and supportive measures.
II. Therapeutic measures.
III. Termination of pregnancy.

I. Preventive and Supportive Measures

1. Education—seek early prenatal care.
2. Diet.
   a. Force fluids to 3,000 to 5,000 cc daily.
   b. Limit weight gain to 18 to 20 pounds.
   c. High protein—low carbohydrate diet —early.
   d. Low salt—no soda—after six months.
   e. Supplemental calcium, iron and vitamins.
   f. For excessive weight gain or edema:
      1. Magnesium sulfate, 1 teaspoonful in water every second morning.
      2. Ammonium chloride, 8 grams daily for four days.
      3. Rest.

The preventive measures above need a little further discussion. Most patients do not consume enough fluid; therefore, they are urged to drink plenty of water. In order to limit the weight gain, the high protein—low carbohydrate diet is outlined as follows. It consists of:

1. Proteins.
   (a) Lean meat, fish or fowl twice daily.
   (b) Milk—three or four glasses of skimmed milk a day, between meals and before retiring. *Nothing else between meals.*
   (c) Eggs—1 or 2.
   (d) Cheese—1½ ounces.
2. Other.
   (a) Fresh vegetables.
   (b) Salads.
   (c) Fruit—only twice a day.
   (d) Bread—1 slice of whole wheat a day. *No sandwiches.*
3. Plenty of water.

Most pregnant women need more than three meals a day. For this reason milk is suggested between meals and before retiring. This will frequently tide them over and avert the temptation to eat food of a carbohydrate variety. In certain cases, it may be necessary to resort to anorexigenic or appetite decreasing drugs, such as Dexedrine sulfate which may be given in 5 mgm. doses at 7:00, 11:00 and 3:00.

Beginning with the sixth month of gestation, a low sodium, no soda diet is particularly important. The best way to limit salt is to instruct the patient specifically to take the saltcellar *off the stove and out of the kitchen.* Allow other members of the family to season food on their own plates so the pregnant mother does not receive salt in "left-over" food the next day. Some salt substitutes may be given to the patient. Avoid specifically the following high salty foods. These we usually outline to the patient:

1. Salt
2. Soda
3. Ham
4. Bacon
5. Butter
6. Nuts
7. Potato chips
8. All salty things

The patient is likewise warned against "saline binges," especially ham, french fried potatoes, popcorn, etc.

In spite of these suggestions, if the patient develops a sudden weight gain, *desalting measures* are outlined:

1. Epsom salts—1 teaspoonful in water every other morning is given as a saline cathartic. It also acts as a central nervous system depressant.

*Read before the Kentucky Academy of General Practice, Cincinnati, Ohio, April 22, 1954.

**Professor of Obstetrics, Director of Department of Obstetrics, University of Cincinnati College of Medicine.

2. Ammonium chloride is likewise given in many instances at the rate of 8 grams a day as follows:
   4 (0.5) gram tablets 4 times a day for 4 days.
   Often following this, the weight drops from 8 to 10 pounds in a few days. Some caution should be used if the patient is a diabetic. This regime may be repeated after a few days, if necessary.

To supplement the desalting process mentioned above, a more strict diet is given to the patient. At this point it is better to give her a specific list of foods which are permitted, than to give her a list of foods to avoid. Our outline for this *specific low salt diet* is as follows:

1. Lean beef or fowl.
2. One or two eggs.
3. Milk—four glasses—plenty of water.
4. Rice
5. Potatoes, boiled or baked.
   No salt or butter may be used on the rice or potatoes.
6. A pitcher of fruit juices daily.
7. Nothing else.

Office visits beginning with the seventh month should be at two week intervals and during the last few weeks at intervals of one week or less when a patient is not well controlled.

Should toxemia develop in spite of the above measures, or should a patient be first seen with toxemia, as evidenced by hypertension over 140/90, edema and albuminuria, then therapeutic measures must be instituted.

II. Therapeutic Measures

1. Preventive and supportive measures as above, plus,
2. Hospitalize for better control.
3. Sedatives—only magnesium sulfate (a central nervous system depressant) 5 cc of 50% solution given intramuscularly every 6 to 8 hours. (10 cc for eclampsia).
   At bedtime a barbiturate in small amount may be given for sleep.
4. Fluids—5% glucose in distilled water plus oral intake to 3,000 to 5,000 cc daily. (Restrict in case of anuria or lower nephron nephrosis).
5. Vaso-depressor substances.
   A. Veratrum.
   a. Inject 0.2 cc (3 minims) of Veratrone (Parke Davis & Co.) or 0.5 cc of Unitensin (Irwin, Neisler & Co.), intramuscularly every two hours for pulse over 70 or blood pressure over 140/90.
   b. In severe cases, particularly in eclamptics with convulsions, start an intravenous of 1,000 cc 5% glucose in water to which has previously been added Veratrone 2.0 cc (0.2 cc per 100 cc of solution), or Unitensin 5.0 cc (0.5 cc per 100 cc of solution). This is usually run at the rate of 75 to 100 cc per hour. Blood pressure and pulse are recorded at 10 minute intervals during the first hour, thereafter at hourly intervals. The blood pressure level may be titrated by increasing or decreasing the rate of flow.
      In the presence of eclampsia 0.2 cc of Veratrone or 0.5 cc of Unitensin is injected slowly into the tubing in an acute single injection immediately, and followed by the slower titrating method.
      After 8 to 48 hours of intravenous therapy, discontinue intravenous infusion of Veratrum and continue with muscular injections as in (a) above.
   Note. Nausea and vomiting, burning sensation and diaphoresis may be noted as harmless side effects of the drugs. Bradycardia, if marked, may be easily controlled by the injection of 1/200 gr. of Atropine.

B. Apresoline.

Recent experiments in this department have shown that Apresoline (a hydrazinothalazine compound) is an excellent vaso-dilator in toxemia of pregnancy. Intravenous doses of 30 mgms. produce a drop in blood pressure lasting from 6 to 22 hours. Side effects are minimal. Experiments also are in progress on the use of combination therapy, Apresoline and Veratrum, since there seems to be a potentiating effect with both drugs.

It will be noted that sedatives other than magnesium sulfate are not employed. We feel that they obscure and prolong unnecessarily the unconscious state, contributing definitely to respiratory embarrassment and pulmonary edema.

With many others, we believe that a generalized wide-spread underlying abnormal vasopressor activity or arteriolar spasm is characteristic of toxemia. This has been demonstrated as early as the 20th week of gestation, by poor response

to autonomic blockade and by the presence of atherosis in decidual vessels—far in advance of other clinical evidence of impending toxemia. Eventually weight gain, edema, hypertension and albuminuria develop. Hypertension is the result of this abnormal vasopressor activity. It is clinically one of the most constant signs of the disease, without which it is practically impossible to classify a case as pre-eclampsia. Vaso-constriction occurs in the precapillary arterioles and produces:

1. Diminished blood flow—anoxia.
2. Increased capillary permeability—edema and stasis.
3. Changes in the vessel walls—thrombosis, hemorrhage, ischemic necrosis.

When the above outlined process is applied to specific organs, particularly brain, eye, liver, kidney, uterus or placenta, it is not difficult to appreciate either the development of the symptom complex or the seriousness of toxemia.

Together with patho-physiologic studies of abnormal vaso-pressor activity and hypertension, studies have been made of drugs which dilate the blood vessels—vaso-depressor substances. Among these, the veratrum alkaloids, used empirically but effectively for many years in Cincinnati, remain unsurpassed to date (with the possible exception of some new synthetic preparations, the hydrazinothalazine compounds), in overcoming the abnormal arteriolar spasm in pre-eclampsia and eclampsia alone, or when superimposed on pre-existing chronic hypertension. When given intra-muscularly or preferably intravenously in 5% glucose in distilled water, veratrum produces a marked arteriolar vaso-dilation with the consequent drop in blood pressure. It has been recently demonstrated that veratrum preparations do not act on the veins. For this reason, postural hypotension is not present, as with sympathetic blockading agents such as tetraethylammonium chloride and spinal anesthesia. The drug also does not affect the cardiac output. Urinary output is temporarily decreased but subsequently and soon compensated by a marked polyuria. The temporary decrease is harmless to the patient. Thus the available evidence indicates that an integrated arteriolar vaso-dilation with a decrease in peripheral resistance and increased blood flow to major organs, including particularly the kidney, are the result of veratrum administration. Improvement of the circulation occurs and better oxygenation results. The vicious cycle of vaso-constriction, diminished blood flow, anoxia, thrombosis, edema, hemorrhage and necrosis is broken. Convulsions cease without sedation, other than magnesium sulfate which is of benefit.

III. Termination of Pregnancy

No attempt is made toward terminating pregnancy even in the eclamptic before 48 hours. This is often delayed from 4 to 8 days. Frequently labor supervenes spontaneously during the stabilization or waiting period. Depending upon the stage of gestation, response of patient to therapy, quantity of albuminuria, condition of infant and condition of the cervix, one of two choices is open:

1. Induction of labor.
   a. Sterile vaginal examination with stripping of the membranes.
   b. Possible rupture of the membranes if the cervix is found to be dilated and amenable.
   c. Carefully controlled Pitocin stimulation.
2. Caesarean section.

Following delivery 10 cc of 50% magnesium sulfate is invariably given intramuscularly. Veratrum by hypo is continued for several days, depending upon the blood pressure and pulse which are recorded at regular intervals until they become stabilized. Fluids are forced and the high protein, low salt diet continued.

Summary and Conclusion

The ideal treatment for pre-eclampsia and eclampsia awaits discovery of the basic etiologic process. In addition to the preventive, supportive and therapeutic measures outlined above, the vaso-depressor drugs offer an adjunct in the treatment which has proved to be of decisive value.

In conclusion, an outline for the prevention and management of toxemia of pregnancy has been presented.

The Foreign Operations Administration of the U.S. Government is preparing to spend $480,500 to finance postgraduate study in this country for 100 European physicians. The American College of Surgeons, under contract to FOA, will direct the entire operation. Much of the study will be designed to acquaint the foreign physicians with American hospital techniques.

The Use of Gamma Globulin in Measles and Poliomyelitis*

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The use of gamma globulin as a tool for the prevention of measles is well established so far as the efficiency of this agent is concerned. Despite the fact that gamma globulin or one of its related antibody containing materials has been used for many years in the prevention or modification of measles, there still exists considerable question as to the indications for it. It is established beyond question that, given in proper amounts and at the proper time, gamma globulin can modify or prevent measles.

Indications for Prevention

There are two general categories of conditions which demand the use of preventive doses of gamma globulin. The first definite indication is the presence of some other active disease in a susceptible individual exposed to measles. Perhaps the most important of these conditions would be some manifestation of active tuberculosis, and acute or convalescent rheumatic fever. Of course, there may be many other acute or chronic diseases existing in a patient which would be made more severe or complicated if the patient had an unmodified attack of measles.

The second general category is that of the control of measles in hospitals or institutions caring for children. In an acute disease children's hospital in times of measles epidemics, it is often advisable to give preventive doses of gamma globulin to all susceptible children admitted to the hospital. When a case of measles develops in an acute disease hospital, all susceptible children should be given preventive doses of gamma globulin unless their particular condition is such that they may be discharged during the incubation period and perhaps simply be given modifying doses of gamma globulin. In children's homes and convalescent homes the decision as to whether to prevent an epidemic of measles depends upon the type of children at the institution. Sometimes, as in the case of orphans' homes, it is better to give modifying doses of gamma globulin and allow the children to develop the disease and thus develop permanent immunity.

Dosage of Gamma Globulin for Prevention of Measles

The dosage for prevention of measles depends upon three factors. Firstly, the weight of the patient; secondly, the duration of time from exposure to the time of giving of gamma globulin; and thirdly, upon the intensity and duration of exposure. Dosages for individuals when given within five days after contact are as follows.

Nonsibling contacts: 0.05 to 0.07 cc. per pound

Sibling contacts: 0.075 to 0.125 cc. per pound

If the preventive dose is given after five days the dose should be double or triple. It is very questionable whether measles can be prevented after the eighth day of the incubation period.

Effectiveness of Prevention

If gamma globulin is given in proper doses during the first week after exposure, one can be extremely certain of effective prevention. It should be stressed here that preventive doses should never be used simply for the convenience of the patient or the family, since the child may later be exposed unknowingly and may develop a severe attack of the disease. The duration of effectiveness of the gamma globulin for prevention is probably not greater than ten days to two weeks.

Indications for Modification of Measles

There is considerable difference of opinion among authorities as to the selection of patients in which modifying doses of gamma globulin should be used. In general it may be said that the younger the patient the more severe the attack will be and the more serious and more frequent the complications. Conversely, the older child above five or six years is better able to withstand an unmodified attack of measles and complications are somewhat less frequently seen.

Nowadays our main concern in measles is the complication of encephalitis. So the problem is really whether gamma globulin in modifying doses prevents or attenuates encephalitis, or decreases its occurrence. There is excellent evidence compiled

*Read before the Third Annual Scientific Assembly of the Kentucky Academy of General Practice, Cincinnati, Ohio, April 21-22, 1954.

indicating that encephalitis is much less frequent following a modified case of measles than an unmodified.

Statistics concerning the frequency of measles encephalitis vary tremendously depending upon the particular epidemic studied. Thus it is difficult to make absolute comparisons between different years and different epidemics. The incidence may vary from 1.5 cases per thousand in the usual epidemic to as high as 1 case per five hundred in more severe epidemics.

It is certainly true that measles encephalitis may follow modified measles. However, almost all cases are extremely mild and the recovery is usually complete in contrast to the generally poor prognosis in encephalitis following an unmodified attack. Here the general figures are a recovery rate of 50%, a mortality rate of 10 to 20%, and a sequelae rate of 30 to 40%. In our experience on the Contagious Wards of the Cincinnati General Hospital we have not observed a definite case of encephalitis following a modified attack of measles, but during epidemic years we see ten to twenty cases of encephalitis following unmodified cases.

Most cases of measles encephalitis occur in the first seven years of life. However, cases are seen with decreasing frequency up to thirty years of age. It would, therefore, seem sensible to attempt to modify every case of measles in which the time of exposure is known. At the present time, of course, it is extremely difficult to get gamma globulin, and in Ohio during this past severe epidemic we have been unable to get gamma globulin for children over three years of age unless there is some reason such as other illnesses, or for children in institutions. We believe this is a serious mistake especially when, as we shall see later in the paper, gamma globulin had very little use in the field of poliomyelitis for which it is being conserved at the present time.

Dosage for Modification

Nonsibling contact: 0.01 to 0.02 cc. per pound

Sibling contact: 0.02 to 0.03 cc. per pound

Results of Modification

In general, the immunity following a modified case of measles is comparable to that following an unmodified case. Proved secondary attacks following modification are extremely infrequent and generally mild in nature. We have emphasized the infrequency of encephalitis following modified measles as compared to unmodified. The same may be said of other less serious complications of measles, such as pneumonia both primary and secondary and other secondary infections. The case for the use of gamma globulin in the prevention of measles in all age groups is, therefore, an extremely strong one and the objection to the use of gamma globulin in the older age group has very little to support it.

The Use of Gamma Globulin in the Treatment of Measles Encephalitis

Louis Odessky et al.[1,2] in two recently published papers have reported a fairly large series of patients with measles encephalitis who were treated with therapeutic doses of gamma globulin. In the past, attempt has been made to modify the course of measles encephalitis using such substances as whole blood, pooled blood, pooled serum, convalescent measles serum, and placental gamma globulin. The effectiveness of these agents has always been extremely questionable. The group in Brooklyn felt that in their series of patients treated with large doses of gamma globulin excellent results were obtained. They suggested a dosage consisting of 1 cc. per pound of body weight except that not less than a total of 30 cc. be given to any young child. They suggest additional quantities in the sicker individuals, that is, an additional 10 cc. for children under six years of age if their temperature is over 103° F. and an additional 20 cc. to children over six years of age if the temperature is over 103° F. The authors felt that the results were very striking in their series of patients. The results of their study can be seen in the accompanying table. (Page 766)

At the Cincinnati General Hospital we have attempted this year to follow their plan of treatment as closely as possible. So far we have treated ten cases of rather severe measles encephalitis and have not been impressed by the effectiveness of gamma globulin. We have had one death and the other patients seem to follow a course similar to those who, in past years, have received no gamma globulin. We have not fully studied these patients nor are there enough to make any definite conclusions, but certainly far more study will have to be undertaken before gamma globulin can be considered a really effective therapeutic agent in the treatment of measles encephalitis.

Table I. Gamma Globulin In Measles Encephalitis and Encephalomyelitis: Comparative Results OfThree Groups Of Patients

Total Dose of Gamma Globulin c.c.	Number of Cases	Clinical Picture On Admission		Results			
		Severe Per cent	Moderate Per cent	Died Per cent	Severe Residuals Per cent	Moderate Or Minimal Residuals Per cent	Complete Recovery Percent
None	14	57	43	14	7	36	43
4-16	12	67	33	25	0	25	50
20	15	80	20	0	7	33	60

Taken from data of Louis Odessky et al.[1]

The Use of Gamma Globulin in the Prevention of Rubella (German Measles)

The problem is entirely different in the prevention of rubella than the problem of prevention or modification of measles. Prior to 1941 rubella was considered to be an extremely innoxious disease and no one showed concern over the illness. However, in 1941 Gregg[3] in Australia demonstrated the amazing frequency of severe fetal damage in infants delivered of mothers who had rubella during the first three months of their pregnancy. In his series, 100% of the infants had severe congenital anomalies. Subsequent studies in the United States, England, and European countries have demonstrated a similar relationship, although the percentage of involved infants has not been as great. The percentage of defects have been between 50 and 90%. The most frequent anomalies seen are congenital cataracts, deaf-mutism, congenital heart disease, and microcephaly. Therefore, it has been felt by many physicians that the presence of rubella during the first three months of pregnancy is an absolute indication for therapeutic abortion.

The problem has come up as to whether gamma globulin can be an effective agent in preventing the occurrence of rubella in susceptible pregnant women during their first three months of pregnancy. There still is a question as to the effectiveness of gamma globulin in the prevention of rubella. One of the difficult factors is that it is impossible to determine whether a woman is susceptible or not since the history of having had an attack or not having had an attack of rubella is frequently unreliable. There is fairly good evidence that when gamma globulin is used in large doses in the earlier days of the incubation period that rubella may be prevented. If gamma globulin, obtained from the blood of convalescent rubella patients is available, a dosage of 4 cc. is probably sufficient. If gamma globulin obtained from pooled blood is used, which is the usual preparation available, the dosage must be much greater. The usually accepted dosage is 0.2 cc. per pound of body weight with a probable minimal dose of 25 cc.

It should be emphasized here that by far the best prevention of rubella in the pregnant woman is to make sure that all individuals have natural immunity by the time they reach adult life. Therefore, definite community programs should take advantage during both epidemic and endemic periods of rubella to thoroughly expose all children of both sexes; the females so that they may be immune and the males to decrease the likelihood of their developing a case of rubella during a subsequent pregnancy of the mother.

Gamma Globulin in the Prophylaxis of Poliomyelitis

Experimental work on animals has demonstrated that large amounts of gamma globulin given before infection to animals will prevent paralytic poliomyelitis. If large enough doses of antibody are given before inoculation of the virus, it is possible to prevent the disease even when the virus is injected directly into the brain. Unfortunately the doses, when applied to human beings, are much too large for practical use.

The object of the field studies with gamma globulin in 1952, therefore, was not to establish whether gamma globulin could, in large doses, prevent paralytic polio but to see whether relatively small practical doses in actual use during the polio season would modify the disease and prevent or minimize paralytic manifestation. An arbitrary dose of 0.14 cc. of

gamma globulin per pound of body weight was selected. This dosage was selected only because it was practical and not because of any experimental evidence that this amount of gamma globulin would provide enough antibody to remain detectable for any period of time in human beings.

The field tests were planned and executed by Dr. Hammon[4,5] and his associates and the following conclusions reported. The following conclusions are taken from an excellent discussion of this entire subject by Dr. Albert Sabin[6] and it may be noted here that the major part of this review has been freely taken from this article and also from personal discussions with Dr. Sabin.

Conclusions Reported

On the basis of the combined results of the three field tests, Hammon and his associates reached the following conclusions regarding the effectiveness of gamma globulin in the dosage used:

1. The disease was not prevented in those who received gamma globulin one week before the onset of first symptoms, but it may have been made milder.

2. Between two and five weeks after injection there was a marked preponderance of cases among those receiving gelatin as compared to those inoculated with gamma globulin, suggesting that this dose of antibody administered either before infection or very early in the incubation period could prevent paralysis.

3. After the fifth week there was no longer any significant difference in the incidence of the disease among those inoculated with gelatin or gamma globulin, suggesting that the dose of antibody was so small that its effect could not last more than about a month.

The final results in all three field tests undertaken, in which 55,000 children received either gamma globulin or gelatin, showed that there were 31 clinically diagnosed cases of polio, regardless of severity, among those inoculated with gamma globulin and 73 among those inoculated with gelatin. Dr. Sabin points out that this would be a significant result in favor of gamma globulin if one could be certain that it was not, in particular, due to an artificial increase in the number of cases among those receiving gelatin, and that it was repeatable with different lots of gamma globulin in different epidemics. While Dr. Hammon and his group felt that the results of these preliminary studies proved beyond doubt the effectiveness of gamma globulin in the prophylaxis of polio, Dr. Sabin by further analyzing the results has shown in the accompanying chart far different conclusions, and therefore advised strongly against using gamma globulin in an uncontrolled manner during the 1953 season.

Interpretation of the chart, by separating the three areas of study, demonstrates clearly that the figures obtained from the study in Utah must be disregarded because the number of cases was too small for consideration. The results in Texas were certainly not very impressive, and beginning with the third week after closure of the clinics the incidence was the same in all groups—uninoculated, gamma globulin, and gelatin. The results in Iowa, however, were unanimously and strikingly in favor of gamma globulin, not only during the first two weeks but also during the fourteen weeks following the closing of the clinics. Dr. Sabin again points out that we are dealing with a small number of cases and that although the results are significant, they may or may not be repeatable and that the batch of gamma globulin used may have varied in antibody, containing more than that used in Iowa and Texas. Although he urgently advised caution and further study before extensive uncontrolled injections of gamma globulin were to be given, Dr. Hammon and his associates under pressure from the National Foundation, the public press, and the hysterical fear of the laity concerning polio decided to go ahead with mass inoculations both during epidemics and in household contacts.

As everyone knows a plan was put into

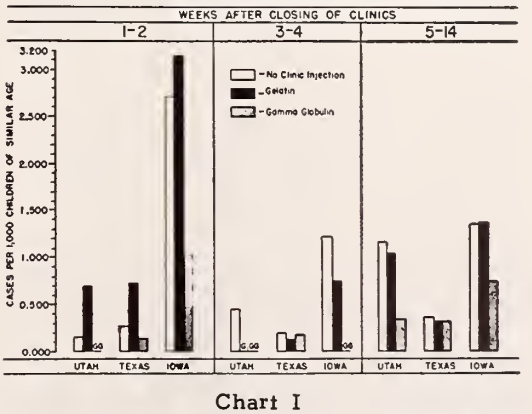


Chart I

This chart was prepared by Dr. Albert Sabin[6] from data collected by Dr. Hammon and his associates[5].

effect last summer to utilize the total amount of gamma globulin available in the country (about one million average doses) to attempt an all out yes or no answer to this problem. No serious experimental studies were undertaken as to the proper dosage or the exact concentration of antibody in various batches of gamma globulin. We now have the results of last summer's massive effort as reported in the March 27th, 1954 issue of the Journal of the American Medical Association.[7] The evaluation undertaken by a large group of investigators was divided into two phases. Firstly, the evaluation of mass use of gamma globulin in epidemics and secondly, the evaluation of contact use. There are extensive figures and epidemiological considerations concerning the results of the gamma globulin prophylaxis. We shall only quote here from the conclusion of this Commission.

Evaluation of Mass Use

"The mass use of gamma globulin carried out on a large scale in 1953 as a method to prevent paralysis in poliomyelitis infection was done as a public health measure in response to a widespread demand and not on an experimental basis. As such, attempts to draw conclusions regarding its efficacy have not been easy and in many instances impossible. In any event, the method of analysis of carefully compiled and extensive data on the use of gamma globulin in those epidemic areas and populations where it might have been expected to be effective did not yield statistically measurable results. Therefore, its value in community prophylaxis as practiced during 1953 has not been demonstrated. Nevertheless, the committee cannot say that the use of gamma globulin for this purpose produced no effect."

Evaluation of Contact Use

"On the other hand, the data on the efficacy of gamma globulin in contact use that have been accumulated in 1953 are considered to be adequate for reliable conclusions. They indicate that, with the preparations involved and in the dosages used, the administration of gamma globulin to familial associates of patients with poliomyelitis has had no significant influence on (1) the severity of paralysis developing in subsequent cases; (2) the proportion of nonparalytic poliomyelitis occurring in subsequent cases in which gamma globulin was given before the onset; and (3) the classic pattern of familial aggregation of cases in the country at large."

The committee, therefore, recommended that a careful consideration be given to present procedures and methods of national gamma globulin distribution and utilization. At the present time The National Foundation for Infantile Paralysis has invested some nineteen million dollars in stock piling huge amounts of gamma globulin for use this coming season. Many investigators, including Dr. Sabin, feel that this gamma globulin should absolutely not be used in a manner comparable to last summer. Certainly the use in household contacts should be completely abandoned. If gamma globulin is to be used at all, it should be used experimentally under controlled conditions in the early stages of what would appear to be an epidemic in any given locality. Perhaps this information would give a more definite answer as to the possible value of gamma globulin prophylaxis under epidemic conditions. At the best, however, gamma globulin certainly is not going to be a dramatic or effective weapon against poliomyelitis.

Vaccinia Immune Gamma Globulin

A brief mention may be made of a limited use of a specialized type of gamma globulin in the prevention and therapy of serious complications of smallpox vaccination. Vaccinia immune gamma globulin is a solution of the globulin component of human blood collected from volunteer donors of the Armed Services who have been successfully vaccinated against smallpox from four to eight weeks prior to the blood donation. A group at the University of California Medical Center headed by C. Henry Kempe[8] has studied this preparation in specifically preventing smallpox in exposed susceptible family contacts of smallpox cases in India, and they found the material to be effective in preventing the disease.

Of course, our need for such a preparation in this country from the standpoint of preventing smallpox is practically negligible. However, they feel they have obtained promising results in three conditions which are occasionally seen as a complication of vaccination. These three conditions are generalized vaccinia, eczema vaccinatum, and progressive vaccinia (failure to produce antibodies). In a letter sent to public health officials and to contagious hospitals, Doctor Kempe offers the material free of charge for the

use in these conditions and this material may be obtained from Doctor Kempe through the following channels:—Telegraphic or telephone request should be addressed to C. Henry Kempe, M.D., Department of Pediatrics, University of California Hospital, San Francisco 22, California, Montrose 4-3600, Extension 371. If calls arrive at night time, the University of California Hospital operator will notify one of the laboratory staff at one of the following three telephone numbers:

1. C. Henry Kempe, M.D., PLaza 5-3024
2. Mary Jean Morse, DIamond 4-9375
3. Melvin Lee, BErkeley 7-6610-R

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The Diagnosis and Treatment of Diabetes Mellitus*

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The diagnosis of diabetes mellitus will, in many instances, be strongly suggested by the classical symptoms of excessive thirst, increased appetite, polyuria, weight-loss and weakness. A high index of suspicion of the disease must be maintained, however, if we are to find the many, as yet undiagnosed, mild to moderately severe cases. The presence of one or more of the less characteristic symptoms may be the lead which eventuates in a diagnosis. Unexplained peripheral neuritis, vague gastrointestinal complaints, anal or vulvar pruritis, peripheral artery disease, angina pectoris or ECG evidence of coronary sclerosis, furunculosis, cataracts, progressive impairment in vision, all should make us suspicious and result in more specific diagnostic studies. The finding of sugar in the urine is, of course, the most commonly used diagnostic screening procedure, but should never be relied upon for the acceptance or rejection of a diagnosis of diabetes mellitus.

Predisposition

There are two very important predisposing etiological factors in diabetes mellitus. The first is that of heredity. The inheritance of the predisposition to development of the disease is a well established fact and follows a generic pattern. It seems that the inherited predisposition is a Mendelian recessive characteristic. This is borne out by the fact that a diabetic and a non-diabetic rarely reproduce diabetics, but their immediate offspring are carriers. If both parents are diabetic, their children will almost certainly inherit the disease. If neither parent is diabetic, but one of each of their parents has had the disease, the chances are one to four that their offspring will eventually develop the disease. It should be remembered, however, that the child may manifest evidence of the disease before it becomes apparent in the parent. Secondly, obesity increases the susceptibility to the disease. To be sure, only a small percentage of obese persons are diabetic, but it is significant that nine out of ten diagnosed diabetics are overweight. We can surmise that relative insulin deficiency is present in obesity and we know that this deficiency is often reversible by a return of the individual to normal weight. In addition, the continued increased demand for greater insulin production in overweight individuals may, by further exhaustion of an already tired pancreas, precipitate clinical manifestations in persons already predisposed to the disease.

Detection

Screening tests for the detection of diabetes should be simple. The routine urinalysis is most commonly used, and rightly so. However, if the desired information is to be obtained, the urine specimen should be collected at a fairly specific time, best one to three hours after a normal meal. Many mild or even moderately severe cases of diabetes mellitus will be overlooked if a morning or fasting specimen is employed. The urine specimen

*Read before a meeting of the 14th Councilor District of the Kentucky State Medical Association, Prestonsburg, April 7, 1954.

should be examined soon after collection, since it has been found that a strongly positive urine may, on standing for several hours in warm surroundings, give a negative reading. It is wise to consider any glycosuria as indicating diabetes until proven otherwise. Certain rare, non-diabetic conditions, however, must be kept in mind; namely, renal glycosuria, alimentary glycosuria, glycosuria as a result of lesions of the brainstem, lactosuria in pregnancy, and fructosuria. It is safe to say, however, that glycosuria with ketonuria is pathognomonic of diabetes mellitus. The urinalysis for sugar done during certain disease states will often unmask an unsuspected predisposed or mild diabetic; namely, acute febrile illnesses, treatment with ACTH or cortisone, hyperthyroidism, acromegaly and Cushing's disease, due to the activation of the adrenal cortex and the resulting insulin antagonism.

Determination of blood sugar levels is, of course, the means of conclusive diagnosis of diabetes mellitus. A diagnostic blood sugar should be drawn 2½-3 hours after a full normal meal. If values above 130 mgs.% are found, a glucose tolerance test is indicated. If values well above this figure are found, a positive diagnosis is justified without a sugar tolerance test. Fasting blood sugar determinations will miss a large percentage of the mild cases. The sugar tolerance test should particularly be employed in the doubtful cases. If a tolerance test is to be done, the patient should be prepared by taking a full diet, particularly heavy in carbohydrates, for 3-5 days prior to the test. The oral test is performed by giving the patient 100 grams of glucose in solution. If the blood sugar reaches a peak of no higher than 200 mgs.% in 1-1½ hours, and returns to the normal level in 2½-3 hours, diabetes can be ruled out. It is best to use the three or even four hour test. In rare instances the intravenous sugar tolerance test should be used; namely, in the presence of chronic gastrointestinal conditions such as sprue, pyloric obstruction, diffuse regional enteritis, etc. where there is faulty absorption from the gastrointestinal tract. Tolerance curves simulating the diabetic curve may be encountered in chronic liver disease, diffuse pancreatic disease, adrenal disease, hyperthyroidism, and in starvation, so should be constantly kept in mind.

Treatment

Diet is, of course, the mainstay in the treatment of diabetes mellitus. Many factors have to be considered in prescribing the proper diet: whether the patient is juvenile or adult, overweight or underweight, the occupation and activities, and, by all means, the patient's likes and dislikes in regard to various foods. At the outset we must state that the diet prescription should be given on the basis of optimum weight for the patient, and not his actual weight. The diet should be as normal in variety as is possible and should take into consideration any food idiosyncracies or allergies of the patient. If full cooperation is to be obtained, this last fact is essential. As a general rule, the average adult needs 1½-2 grams of protein per kilogram of body weight, 150-250 grams of carbohydrate, and the remainder of the calories may be obtained from the fats. Juvenile diabetics should have 2-3 grams of protein per kilogram of body weight. It is best not to give the total calories in only three meals, but to give a portion at bedtime, or even in mid-afternoon, as may be indicated by the Clinitest or blood sugars. Variations will be made necessary by the type of insulin used, the time of its administration, and the times of appearance of glycosuria. The working habits of the patient may also necessitate alterations in the dietary schedule. A well worked-out series of diabetic diets, in six caloric categories ranging from 1200-2600 calories, has been made available by the American Diabetic Association and can be obtained on request for a very nominal charge. In them the dietary instructions are simple and easily understood. The food exchange lists furnished with these diets are an invaluable aid in obtaining the proper cooperation of the patient and, consequently, the desired dietary results. I feel that diabetic scales are unnecessary, and that the employment of household measures in allocating the diet is entirely adequate. Once the diagnosis of diabetes is made, we must decide whether insulin is to be used. In general, any diabetic who cannot maintain his optimum weight while doing his usual work, adhering strictly to his properly prescribed diet, and remain free of glycosuria and hyperglycemia, should have insulin. The underweight and the juvenile diabetic will almost always require it. The obese adult diabetic should almost never require it. On the proper weight-reducing diet the obese diabetic will usually be very satisfactorily controlled. It should be remembered, too, that it will be almost impossible to accomplish weight reduction in the obese if insulin is being employed. There is merit in giving *most* diabetics, except

the obese, insulin, early in the course of their treatment. Thereby, a fatigued pancreas is allowed, perhaps, to recover some degree of reserve and, in many instances of mild disease, the insulin may need be used for a relatively short time only. All diabetics. during periods of acute and severe infectious disease, should receive insulin.

Choice of Insulin

The choice of the type of insulin to be used is an important one. Regular insulin, or crystalline insulin (which is identical in time of action and effect), begins its effect in 3-4 minutes, reaches its peak action in 3-4 hours, and has completed its effect in 6-8 hours. It is the insulin of necessity in diabetic coma and acute febrile illnesses. The dosage must be dictated by frequent tests for glycosuria and blood sugar levels. Protamine zinc insulin is still in common usage but will, I believe, soon be relegated to obsolescence. It begins its effect in 1-2 hours, reaches peak action in 8-12 hours, but maintains a gradual diminishing effect for 24-30 hours. Actually, only about 70% is utilized the first 24 hours, 20% the second 24 hours, and 10% the third 24 hours. Because of the likelihood of hypoglycemia reactions during the night hours, the diet should be so arranged that a milk and bread exchange, usually 10-15% of the total daily calories, be taken from breakfast and given at bedtime. I would like to repeat that, with the newer intermediately acting insulins now available, protamine zinc insulin is rapidly losing its place as a single injection insulin. When used, it should be given approximately one hour before breakfast. NPH and globin insulins are intermediate in their times of action. Effect begins in about one hour after administration, reaches peak action in 6-8 hours, and is dissipated in 16-18 hours. With their use, hypoglycemic reactions are more likely to occur from 3-4:30 p.m. When they are used, a milk and bread exchange should routinely be taken from breakfast and given in mid-afternoon. The intermediately acting insulins are very similar in their time of action and effectiveness to the 2:1 mixtures of regular and protamine zinc insulin. Insulin mixtures are often necessary in juvenile and brittle adult diabetes. The most satisfactory mixtures, I believe, are those of regular and NPH insulin. A mixture of 2 units of regular to one unit of NPH is given 15 minutes before breakfast. If glycosuria persists before lunch, the regular insulin should be increased until the glycosuria disappears; if glycosuria is present before the evening meal, the NPH should be increased as indicated. In some instances of severe diabetes, the presence of glycosuria and hyperglycemia before breakfast indicates the need for a supplementary dose of insulin in the late afternoon. This should be NPH or globin insulin and should be given just before or just after the evening meal. The starting dose should not exceed 15 units, and should be increased very cautiously, by 2-4 unit increases every 2-3 days, until the fasting glycosuria and hyperglycemia have disappeared.

When it is felt, by the absence of glycosuria before meals and at bedtime, that the diabetes is well controlled, blood sugar determinations should be done at these times and any indicated adjustments in insulin dosage or diet be made before the situation can be considered to be stable. We must remember that, since physical exercise will decrease the insulin requirement, it is often necessary to reduce the insulin dosage slightly, when the patient gets back to his usual work and activities and away from the relatively sedentary life of his hospitalization. For the same reason, it is advisable that the diabetic take an additional feeding of carbohydrates just before undertaking any unusually vigorous physical exercise such as in an athletic contest.

In recapitulation, in regard to the use of insulin in our diabetic patients, it is well to proceed on the following conclusions:

1. The intermediately acting insulins, NPH or globin, in single dose daily, are to be used in the large percentage of patients, those who are, in degree of severity, between the mild and obese diabetics, who require no insulin, and the severe labile patients.

2. For the very severe or labile patient, the insulin mixture of regular and NPH (or globin) may be more satisfactory. The mixture should be given in a 2:1 or 3:1 ratio, and varied as indicated. It may be necessary to use the mixture dose before breakfast and a supplementary dose of NPH before the evening meal. Ideally, of course, we prefer perfect control of the diabetes, as manifested by a fasting blood sugar of not more than 130 mgs.% and a urine free of sugar in all before-meal specimens. However, in the severe and labile diabetic, it is safer to permit occasional mild glycosuria than to risk re-

peated hypoglycemic reactions. In the diabetic cardiac we should remember that a sick myocardium tolerates hypoglycemia very poorly, so that it behooves us to allow the blood sugar level to remain a little above the theoretical normal. I would repeat that regular insulin is the insulin of necessity in diabetic pre-coma and coma, and in severe infections.

Initial Stabilization

The question of office or hospital stabilization naturally arises once the diagnosis is made. Most mild diabetics can be satisfactorily stabilized and educated by frequent office visits and detailed discussions. The more severe and labile patients should be hospitalized for a period of 10-12 days if at all possible. Hospitalization offers an opportunity for the patient to thoroughly familiarize himself with his diet, learn to administer his own insulin, and to examine his urine for sugar and ketone bodies. Let me stress that it is just as important, if not more so, for the patient to be able to detect ketone bodies in the urine as it is to do the Clinitest. Compressed tablets of nitroprusside compound (Acetest) are readily available and the technique is no more difficult than that of the Clinitest. Both tests should be done when the urine is examined at the recommended intervals. We should furnish the patient with the layman's literature on diabetes mellitus, encourage him to study it thoroughly, and ask him to bring to us for explanation and clarification any points about which he is not entirely clear. Many institutions offer group instructions, some with the aid of movies. The patient should be urged to take advantage of such service when it is available to him. The person who is to be responsible for the diet preparation should, of course, receive the details of diet instruction.

We should not fail to recognize the need for superficial psychotherapy in all diabetic patients. Remember that the patient has suddenly been saddled with the diagnosis of an incurable disease and one with which he will have to wrestle the remainder of his life. The proper psychological approach is essential, especially with the juvenile patient, if we are to receive the necessary cooperation for satisfactory results. The diabetic deserves and should receive, a clear-cut explanation of his disease, what is causing it, why it is necessary that he must do or not do certain things. Acquaint him with the complications which are likely to result from poor cooperation. By all means, reassure him as to the probability of a state of reasonably good health and a normal life span if the rules are followed.

Diabetic Emergencies

The most important diabetic emergencies are diabetic coma and hypoglycemia. Diabetic coma is the end result of a trend of symptoms which should have been recognized in their early stages. Ketosis is never a sudden development and should be suspected by the gradual onset of fatigue, shortness of breath, anorexia, nausea and vomiting, and abdominal pain, and will be confirmed by the finding of ketone bodies in the urine. The causative factors are usually untreated or improperly treated disease, or the occurrence of some acute infectious process such as acute gastro-enteritis, pneumonia, tonsillitis, hepatitis, or urinary tract acute infections. Acute gastro-enteritis is probably the chief offender among the infections. This is logical, since it not only aggravates the diabetes but further favors the development of ketosis by its production of a state of starvation and dehydration. In the early stages, and while the patient is still responsive and able to swallow, it is usually sufficient to treat by giving readily assimilated carbohydrates, such as orange juice, every two hours, and regular insulin every two to four hours, the dose being determined by the Clinitest. A safe rule is to give 25 units for a four plus reaction, 20 units for a three plus, 15 units for a two plus, and 10 units for a one plus reaction. This should be continued until the urine is free of ketone bodies. We must, of course, search for any infectious process which may have been the precipitating cause and treat it adequately.

Coma

When the stage of coma has been reached, in diabetic acidosis, we have a critically ill patient and one in whom prompt, proper and vigorous treatment is indicated. The patient will show air hunger or the so-called Kussmaul breathing, dry skin, soft eye balls, fruity odor to the breath, falling or low blood pressure, rapid pulse and cold extremities. Irreversible peripheral circulatory collapse is the greatest danger. The urine will show strongly positive reactions for sugar and ketone bodies, the blood sugar will be moderately to markedly elevated, and the CO_2 combining capacity of the blood will be below 45 vol.%. Differential diagnosis will be concerned mainly with

cerebro-vascular accidents. These should be eliminated by the history, urinalysis neurological examination, and occasionally by spinal fluid study. Differentiation from hypoglycemia is always necessary and should be done by the presence of ketonuria, the history and the physical findings. Uremic coma will have to be considered, and will be eliminated by the presence of glycosuria, absence of uriniferous odor to the breath, and the eventual finding of a normal blood urea nitrogen. When reasonably sure of the diagnosis, 50-100 units of regular insulin should be given immediately, approximately one-half the dose intravenously and the other half subcutaneously. Prompt transfer to the hospital is indicated. On admission to the hospital an additional 50-100 units of regular insulin should be given in the same manner as the initial dose. The patient is kept warm and a saline venoclysis is promptly started. An indwelling bladder catheter should be put in place, and a urine specimen and a blood specimen for determination of sugar level and CO2 combining capacity taken. 2000 cc. of saline clysis should be administered rapidly and even a third 1000 cc. if the patient is not showing signs of responding promptly from the state of circulatory collapse. If the examination of the urine in one hour shows that the reaction for sugar and ketone bodies is still strongly positive, 50-60 units of regular insulin should be given subcutaneously. It is usual to need 200-400 units of regular insulin during the first five or six hours of treatment. Glucose clysis should not be given until determination of the blood sugar indicates that the blood level has fallen to 200-250 mgs.% and that glycosuria is diminishing. Within 4-6 hours after starting parenteral fluids it is advisable to administer potassium and phosphorus in the fluids, since there is a marked reduction of these elements in the serum as a result of the hydration therapy. One or two grams of potassium phosphate should be included in the saline or saline-glucose infusion in the first 12-30 hours of treatment, and a similar amount in the next 24 hours. In most severe cases, 4000-8000 cc. of parenteral fluid will be needed in the first 24 hours. During this period of vigorous hydration the chest, especially in the cardiac and the elderly patient, should be frequently examined for evidence of cardiac failure or pulmonary edema. As long as the patient remains unresponsive, the urine should be tested every two hours, the blood sugar determination made every four hours, and the insulin dosage and fluids administered as indicated by the results. The determination of the CO2 combining capacity of the blood should be done every 6-8 hours until the result is reported as 25 vol.% or better. If the acidosis is unusually stubborn, the addition of sodium lactate and sodium bicarbonate (1.3% solution) to the parenteral fluids is sometimes most helpful. As soon as the emergency treatment is well under way, a thorough search for infection should be carried out, and, if found, appropriate antibiotics and/or surgical treatment done. Prophylactic antibiotics are always indicated during the period of unconsciousness. Gastric aspiration and the leaving of a residue of sodium bicarbonate solution in the stomach is excellent treatment for the acidosis and is good prophylaxis against aspiration pneumonia from regurgitated stomach contents. As soon as the patient is responsive, diet should be started by mouth. This should be mainly liquids at 2-hour intervals. The most satisfactory are those of a high potassium content such as salty broths, banana, or orange juice. Parenteral fluids should be stopped as soon as a sufficient fluid intake is tolerated orally. From this stage onward the patient should be handled as in the pre-coma acidotic state. When urinalysis, blood sugar, and the CO2 combining capacity of the blood indicate that the ketosis has disappeared and the blood sugar is normal, maintenance diet and intermediately acting insulin should be started.

Hypoglycemia

The blood sugar level at which hypoglycemic reactions occur varies considerably in different individuals but, in general, the reactions most commonly occur when the blood sugar level is 60 mgs% or below. There is a definite time relationship between their onset and the type and time of administration of various insulins. Reactions caused by soluble insulin usually occur 3-6 hours after administration; from PZI in the late afternoon, at night or in the early hours of the morning; with NPH or globin insulin in mid to late afternoon. The precipitating causes are: (1) failure to take the full amount of food prescribed, (2) inadvertent insulin overdosage, (3) unusual lability of the disease, (4) a too vigorous attempt to keep the urine entirely sugar-free, (5) strenuous physical activity, and (6) improper distribution of the diet. As a prophylactic measure, all diabetics taking insulin should carry with them some quickly assimilated

carbohydrate. It goes without saying that he should adhere strictly to his diabetic regime, especially in regard to the taking of the prescribed buffer feedings. If vigorous physical exercise is anticipated, he should take an additional feeding of carbohydrate just prior to the exercise. The early symptoms of hypoglycemia are nervousness and restlessness, hunger, sweating, palpitation, tremor, and sometimes mental confusion, paresthesia, incoordination and ataxia. At this stage, prompt recognition and the ingestion of orange juice, milk, lump sugar, cookies, or other quickly assimilated food will alleviate the symptoms. When the reaction has progressed to the stage of coma, we have a more difficult situation to handle. These patients should be recognized by the fact that they were well until the sudden onset of symptoms. The skin is cool and moist, breathing and blood pressure are usually normal, the eye balls are of normal tension, and the urine is free of ketone bodies. The urine is usually free of sugar, but may not be so, if the urine has been retained in the bladder for some time. If available, 50 cc. of 50% glucose solution should be given intravenously. A second best procedure is to instill sugar solution, orange juice, or other available liquid nutriment into the stomach through gastric tube or nasal catheter. If neither of these measures is available, a ½-1cc. subcutaneous injection of 1:1000 solution of adrenalin chloride, will frequently suffice to arouse the patient by mobilizing glucose from the glycogen stores. Then oral carbohydrate can be given. We must remember that, with the intermediately and long acting insulins, the hypoglycemia reactions are likely to recur in 1-3 hours. Consequently, supplementary feeding every 2-3 hours should be continued for the remainder of the day or night. If there is doubt, in a diabetic patient, whether the coma is due to acidosis or hypoglycemia, concentrated glucose should be given. If it is hypoglycemia the patient will promptly respond; if acidosis, no harm is done.

In conclusion, I would strongly urge that we insist on all of our diabetic patients carrying on their person, at all times, some means of identifying themselves as diabetics.

The Initial Management of Patients With Thoracic Injuries*

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This brief summary of the initial management of thoracic injuries is presented to assist physicians in making a more accurate appraisal of the problems encountered and facilitate more effective early treatment. For obvious anatomical reasons a large group of individuals with thoracic injuries die before there is an opportunity to render medical aid. Another group of patients with thoracic injuries will survive, even if untreated, and therefore require little discussion here. Others will survive for limited periods but will succumb unless early and proper treatment is available. It is with this group that we are especially concerned. The nonoperative measures and less formidable operative procedures are stressed. Late developments and complications are omitted as it should be possible to care for them under more ideal circumstances. Discussions of such problems as traumatic shock, chemotherapy, oxygen therapy, and the use of the ordinary drugs are readily available and are to a large extent omitted from this discussion.

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Classification

Thoracic injuries may be classified as:

1. Injuries involving only the thoracic wall. These may be due to blunt force or to tangential wounds. Such injuries may produce:
   a. Local reaction alone or
   b. Mild to grave disturbances in cardiorespiratory physiology.
2. Intrathoracic injuries which may be the result of:
   a. Nonpenetrating wounds (blunt force). These may produce extensive

damage to such intrathoracic organs as the lungs, heart or esophagus, and may therefore result in hemorrhage, infection, or disturbances in cardiorespiratory physiology.

b. Penetrating wounds. The term "penetrating" used in relation to wounds of the thorax signifies that the thoracic cavity has been entered. Penetrating used in relation to the heart would indicate that the heart had been entered by the weapon or missile. As generally used, it signifies entrance into one of the cardiac chambers.

c. Perforating wounds. The term "perforating" indicates passage through and when used to describe wounds of the chest or heart, it would indicate that the part or organ, including both walls, had been completely traversed.

In the initial management of thoracic injuries one is concerned with (1) the correction of conditions which produce disturbances of cardiorespiratory physiology, (2) the control of hemorrhage, and (3) the prevention of infection. The control of hemorrhage is carried out in essentially the same manner as in other parts of the body and prevention of infection poses no problems peculiar to the thorax, so neither subject is discussed in detail here. On the other hand, certain injuries produce important changes in cardiorespiratory physiology, changes which give rise to characteristic symptoms and signs. It is necessary that the physician who has the responsibility for the care of patients with thoracic injuries be familiar with these physiologic changes, the manner in which they are produced, the physical signs and symptoms associated with them, and, finally, the most effective measures for their relief.

Results of Chest Injuries

Several all important conditions develop only as a result of chest injuries. These may occur singly or in combination in patients with chest injuries from any cause. Unrecognized and therefore without proper management, the results are necessarily poor. If recognized and their mode of production is understood, treatment may be simple. These conditions are:

1. Retention of bronchial secretions with inadequate pulmonary aeration, caused by:

a. Severe chest wall pain

b. Abnormal mobility of the chest wall

c. Depression of the cough reflex through

(1) Unconsciousness

(2) Administration of excessive amounts of opiates

2. Open chest wall with the "sucking sound" phenomenon. A similar condition physiologically is produced by extensive rib fractures with resultant excess mobility of a considerable segment of chest wall, the so-called "flail chest."

3. Pressure or tension pneumothorax with or without mediastinal emphysema.

4. Cardiac tamponade.

5. Massive hemothorax.

Since adequate treatment of these conditions will correct the resulting cardiorespiratory disturbances and thereby aid in resuscitation of the patient, each condition will be discussed in some detail.

Chest wall pain may have serious consequences in injuries which otherwise would be of no great importance. Pain may effectively immobilize the chest wall, thereby making cough ineffectual. This results in retention of tracheobronchial secretions and/or aspirated material. The accumulation of such material in the bronchi interferes with pulmonary ventilation and leads to atelectasis and perhaps even to suppurative pneumonitis. If inadequately treated, such patients may actually go on to asphyxiation. Recognition of such a situation is not difficult.

The patient complains of pain on respiration and on coughing. Cough is ineffectual and auscultation reveals moist rales and/or rhonchi widely distributed over both lungs. More severe cases show dyspnea and cyanosis.

Treatment is directed toward relief of the chest wall pain and clearing the airway of secretions. Pain is relieved by injecting the intercostal nerves of the involved area with one per cent (1%) procaine. This is injected in small quantities (5-10 cc.) below the inferior costal margin, posterior to the angle of the rib. Care is taken not to enter the pleural cavity. It is advisable to inject two interspaces above and two below the obvious area of injury. The procedure is repeated as required. In early or mild cases this will suffice. Adhesive strapping is inadvisable, except when needed for the stabilization of certain flail chest walls.

Patients with retained secretions should have immediate aspiration by nasotracheal catheter. Tracheal suction is easily

done and physicians treating patients with thoracic injuries must familiarize themselves with its technique. Using a fairly stiff catheter (16-18 French) the patient is placed in the sitting or semisitting position with the back supported, and the head and neck dorsally extended. The lubricated catheter is quickly passed through the nose into the pharynx without suction attached. The patient is instructed to take a deep breath and during inspiration the catheter is passed into the trachea. Success is signified by violent coughing and hoarseness. If the patient gags, the catheter is in the esophagus, not in the trachea. Suction is applied intermittently as the catheter is passed into the tracheobronchial tree. Both sides should be aspirated. In some patients effective aspiration can be accomplished only by means of the bronchoscope. Oxygen by nasal catheter is administered if there is evidence of hypoxia. It should be stressed that opiates must be used with particular care in patients with excessive bronchial secretions, and especially in patients who have difficulty in evacuating these secretions.

The importance of an open, adequate airway cannot be overemphasized. In patients with serious cervical or facial injury or in any condition where suction or bronchoscopy is not feasible, or where excessive irritation has been produced by gas or smoke, it is advisable to perform a low tracheotomy so that catheter aspiration can be adequately accomplished.

Open chest injuries produce profound disturbances in intrathoracic physiology. Because of the opening in the chest wall, negative intrapleural pressure is replaced by atmospheric pressure. A number of factors determine the severity of the effects on cardiorespiratory physiology, the most important being the size of the opening in the chest wall. Small openings are in general better tolerated than large ones. If the size of the opening approaches or exceeds the size of the glottis, the patient may get into serious difficulty. Other important factors are the type of wound and the mobility of the mediastinum. If the wound allows air to enter the pleural space but does not permit it to escape, the patient's condition deteriorates more rapidly. Since the mediastinum is usually quite mobile, open pneumothorax generally leads to a shift of the mediastinum to the opposite side with compression of the contralateral lung as well as the lung on the side of injury. The swing of the mediastinum with each respiratory cycle causes poor air exchange and also interferes with the return of venous blood to the heart.

Smaller wounds of this type which give rise to the characteristic sound of air entering or being expelled from the chest have long been known as "sucking wounds." Since this term has no significance apart from the altered physiology of an open pneumothorax, and since wounds often change from the closed to the open type, or vice versa, with changes in tissue plane alignment, there seems to be no logical reason to retain the term. All penetrating injuries of the chest wall are to be considered open (sucking) until careful inspection or actual debridement prove them to be otherwise.

Open wounds must be effectively closed as soon as possible. As an emergency measure a simple occlusive dressing of vaseline gauze is adequate. When the patient has been removed to a location where facilities are adequate, the wound is debrided and an airtight pleuromuscular closure is done. A large catheter (34F-45F) is inserted through an intercostal space into the pleural cavity and is connected to a water-seal arrangement (for evacuation of air and fluid). The wound will be discussed later.

Flail chest is always a serious occurrence and, if the mobilized segment of chest wall is large, it may even be life-endangering. Milder cases are adequately handled by intercostal nerve block supplemented by a stabilizing pressure dressing secured by elastic adhesive. More severe injuries may require the insertion under aseptic precautions of a sterile towel clip around the central rib of the flail segment and the application of light traction. Traction may be obtained by a cord attached to a weight, usually about five pounds, suspended over a single pulley attached to an overhead frame. The intercostal nerves of the involved area should be injected with procaine. Oxygen should be administered.

The terms "*pressure*" or "*tension pneumothorax*" indicate the accumulation of sufficient air in the pleural cavity to compress the lung and thereby seriously interfere with ventilation. If the mediastinum is not fixed by adhesions, the opposite lung may also be compressed.

Patients with pressure or tension pneumothorax are usually dyspneic and cyanotic. The combination of hypoxia and interference with cardiac filling leads to circulatory collapse. There is no essential

difference in the physiologic effects of this condition from the effects produced by open pneumothorax or by flail chest. The trachea and heart shift to the uninjured side.

Treatment consists of (1) decompression, (2) relief of pain by injecting the intercostal nerves on the injured side, and (3) clearing the airway by catheter suction. Manometric determination of the intrapleural pressure is desirable but is not essential. The best way to decompress the pleural space is to insert a soft rubber intercostal catheter connected to a water-seal system into the pleural space through the midclavicular line anteriorly (Fig. 1). In an emergency air may be removed continuously by use of a large-bore needle, syringe, and three-way stopcock. Oxygen is administered. If there is rapid leakage of air (as through a wound in a large bronchus), open thoracotomy is necessary. This problem will be discussed more fully in a subsequent section.

Mediastinal emphysema (emphysema may be subcutaneous or mediastinal) may occur in association with tension or pressure pneumothorax. Such a combination usually indicates a serious underlying injury. Collections of air limited to the subcutaneous tissues may reach startling proportions but fortunately in the absence of gas-forming pathogens seldom endanger life. Air under pressure in the mediastinum interferes with the venous return and may also cause tracheal obstruction.

Air gains access into the mediastinum through perforations of the esophagus, the trachea or mediastinal portions of the main stem bronchi. Also air may dissect along the bronchi and/or blood vessels and gain access to the mediastinum from the lung. In extensive mediastinal emphysema there is apt to be swelling of the neck. In some cases the mediastinal emphysema is associated with subcutaneous air. The diagnosis of mediastinal emphysema is made by hearing the so-called "mediastinal crunch" with the stethoscope and visualizing the air by roentgenography. In cases where air dissects up into the base of the neck the distinctive crepitation produced by air in the tissues is easily elicited.

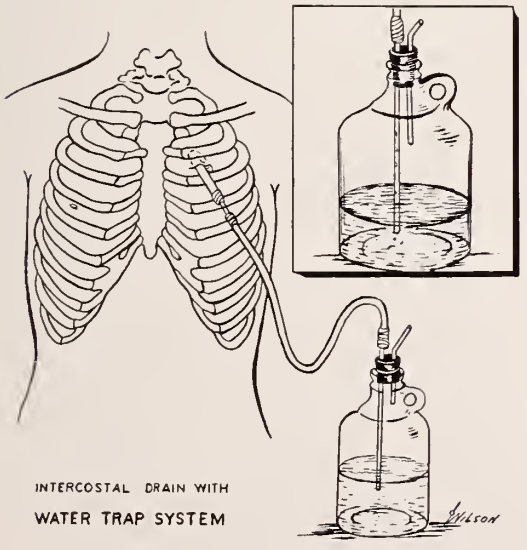


FIG. 1

Treatment ultimately should be directed toward correction of the underlying lesion. If a tension pneumothorax is present, a catheter is inserted into the pleural space and is connected to a water-seal device. If air is present in the mediastinum under sufficient pressure to cause labored respirations and circulatory impairment, a collar type incision should be made at the base of the neck and a finger introduced into the superior mediastinum, thereby permitting the ready escape for air. If the air in the mediastinum is the result of laceration of the trachea or esophagus, open thoracotomy is indicated.

Massive accumulations of blood in the pleural cavity may produce serious physiologic disturbances, as well as the effects of blood loss. There physiologic disturbances may be reductions in lung volume and vital capacity, reduced cardiac filling from obstruction of the mediastinal veins, and compression of the contralateral lung, the result of mediastinal shift. Recognition of these conditions is not difficult. These patients show dyspnea and pallid cyanosis, the percussion note is flat, and the breath and voice sounds are usually distant over the greater part of the chest, but the breath sounds may have a bronchial character posteriorly near the spine. A free return of blood on thoracentesis confirms the diagnosis.

Treatment is directed toward evacuation of blood from the pleural cavity and restoration of the blood volume. Initially, sufficient blood should be removed to relieve the respiratory distress and mediastinal venous obstruction. Meantime, sufficient blood should be administered to restore the blood volume and content to normal. In an emergency blood from the pleural cavity may be citrated, filtered and autotransfused if there is no gross contamination, and if the injury is of short duration. Because of the danger of

hemolysis autotransfusion is unsafe if the injury is of more than twelve hours duration. Aspiration of the pleural cavity should be repeated at frequent intervals until the blood has been completely evacuated and the lung has expanded. As much as 1000 cc. of blood may be withdrawn if the patient develops no untoward symptoms such as cough, faintness, chest pain, or tightness. Aspiration may be repeated in from three to four hours. Oxygen is given by nasal catheter. Chest wall pain is relieved and adequate respiratory excursions are restored by blocking the intercostal nerves with one per cent (1%) procaine.

No chest wound can be said to be progressing satisfactorily unless the following results have been or are being achieved:

1. Bleeding adequately controlled.
2. The patient is totally resuscitated.
3. The tracheobronchial tree has been satisfactorily cleared.
4. The chest wall is stable and painless to the extent that cough and aeration are effective.
5. No significant circulatory disturbances present.
6. All wounds are properly debrided and dressed.
7. Pleural space free or is being freed of blood and/or air.
8. Lung expanded or expanding.

Indications for Immediate Surgery

Indications for immediate surgery in chest injuries are closely allied to the correction of disturbed cardiorespiratory physiology since operation may be necessary for correction. Surgery undertaken without accurate evaluation of these factors is doomed to failure. Certain conditions require immediate surgery, due consideration being given to resuscitation measures. The more important of these conditions are:

1. Open chest wall wound.
2. Continued intrathoracic bleeding.
3. Thoraco-abdominal injuries.
4. Esophageal injuries.
5. Progressive and rapid accumulation of air in the thorax.
6. Certain cardiac injuries.

Open Chest Wall Wound. The principles of initial wound care of chest injuries are the same as wounds elsewhere. They include thorough debridement or wound excision, by bold and generous incision, the opening of muscle planes and wide exposure of the depth of the wound. Minimal removal of skin edges is practiced and especial care should be exercised to remove all devitalized or contaminated muscle, fascia, and foreign bodies (clothing, debris, missiles, loose bone fragments). Direct inspection of the extent of the wound assures the protection of major nerves and blood vessels as well as thorough hemostasis. The wound should be left open if grossly contaminated, if extensive tissue damage is present, and if there is a possibility of a foreign body remaining. If the wound is left open, the wound edges are covered with fine mesh gauze and an adequate dressing applied. If the pleural space has not been opened by the injury, debridement should be carried out so as to preserve its integrity.

If the pleura has been penetrated, foreign material loose in the pleural space and devitalized tissues are sought out and carefully removed. Lacerations of the lung should be sutured. Large quantities of warm physiological saline solution are used to lavage the pleural space. Antibiotics are applied intrapleurally, and an airtight closure of the chest wall defect is made, if necessary by the use of pedicled muscle flaps. Drainage is obtained by placing catheters (34F-45F) in the intercostal spaces anteriorly and posterolaterally connecting each catheter with an underwater-seal system. Suction is seldom indicated during the first forty-eight hours after operation.

Intrathoracic Bleeding. Intrathoracic bleeding must be controlled. Continued bleeding is often from the intercostal or internal mammary vessels, and, if it is not possible to control it by other means, thoracotomy is necessary. Injury to the larger systemic intrathoracic vessels, such as the aorta, is generally rapidly fatal, but patients occasionally survive injury to large pulmonary vessels. Continued severe bleeding from the smaller vessels of the lung is of infrequent occurrence. Careful appraisal of all the problems presented is necessary in making the decision as to whether or not to do a thoracotomy. Features which aid in the decision regarding thoracotomy are: (a) rapid re-accumulation of blood in the pleural space (removal of as much as 2000 cc. of blood within twenty-four hours does not afford proof of continuing bleeding but does strongly suggest it); and (b) patients in shock who do not show continued improvement following the administration of what would seem to be adequate amounts of blood.

For example, if the blood pressure fails to rise to a relatively normal level (above 100 mg. Hg. systolic) after 1500 to 2000 cc. of blood or shows only a transient rise after such an amount of blood, thoracotomy is in order.

Thoraco-abdominal Injuries. Thoracic injuries without continued bleeding or complicated by other important injuries rarely show persistent shock when the disturbances in cardiorespiratory physiology have been corrected. The individual with thoracic injury who shows persistent shock in the absence of serious extrathoracic wounds should be suspected of having continued bleeding or gross contamination of the peritoneal and/or pleural spaces, possibly the result of transdiaphragmatic visceral injury. Blood and bile may be sucked into the chest in right-sided thoracoabdominal wounds. Prompt operation is required in such patients. Continued bleeding due to injury of the heart is discussed elsewhere.

Intra-abdominal hollow viscus perforation or injury of a solid organ such as the liver or spleen in association with intrathoracic injury makes immediate operation mandatory. However, due regard must be given to resuscitation measures. Physical examination together with knowledge of the probable course of the injuring agent helps in detecting the presence of an abdominal injury. Roentgenograms may be of value. Intercostal nerve block is valuable as a therapeutic and as a diagnostic measure, for it usually relieves the abdominal pain and tenderness on the corresponding side if due solely to thoracic trauma. Persistent rebound tenderness generally means peritoneal irritation and, therefore, requires exploration of the abdomen. Shock is usually more marked in thoraco-abdominal injuries than in thoracic injury alone. The associated abdominal wound is especially dangerous because of the likelihood of bacterial contamination, both of the peritoneum and pleura. Early operation is therefore necesasry.

Preoperative correction of altered intrathoracic physiology, endotracheal anesthesia, and complete re-expansion of the lung at the close of the thoracic phase of the operation, are essential safety measures. Thus, the thoracic part of the operation should usually be accomplished first. The surgical approach may be by thoracotomy, thoracolaparotomy, or by laparotomy alone. If the diaphragm is not injured, the approach to the abdominal viscera should be by laparotomy. If the left diaphragm is injured, the combined thoraco-abdominal approach may be used, but frequently both the thoracic and abdominal conditions can be satisfactorily cared for by entrance to the thorax through the bed of the ninth rib and exposure of the organs in the left upper abdomen by wide incision of the diaphragm. On the right side abdominal injuries are best exposed by laparotomy while treatment of the thoracic injuries and repair of the diaphragm are best accomplished by thoracotomy. The diaphragm should be repaired with interrupted cotton or silk suture. Liver injury requires drainage by adequate subcostal incision. Rubber tissue drains are placed dependently and are left in place for at least ten days. The pleural space is drained by catheters (34F-45F) placed anteriorly and posterolaterally and connected with water-seal systems. When early adequate treatment is given, the mortality from combined thoraco-abdominal injuries should not be appreciably greater than the mortality from abdominal injuries alone.

Esophageal Injuries. Perforations or lacerations of the esophagus warrant early transpleural thoracotomy. Esophageal perforation may be demonstrated roentgenographically (including fluoroscopy) by having the patient swallow iodochloral or lipiodol. Barium must not be used. Further evidence may be obtained regarding perforation by having the patient swallow 5 cc. of tincture of methylene blue in 30 cc. of sterile water and by recovering the blue fluid at thoracentesis. It may also help the surgeon locate the injury at operation. When positive evidence of esophageal perforation cannot be established, large doses of antibiotics are given and the patient is observed for a few hours. If the patient's condition deteriorates, prompt thoracotomy is indicated. The perforation in the esophagus is sutured, the mediastinal pleura is left open and drainage of the pleural space is established through two catheters (34F-45F), one inserted through an anterior interspace, the other posterolaterally. Each catheter is connected with a water-seal system.

Accumulation of Air in the Thorax. The rapid and progressive accumulation of air in the thorax usually indicates injury of one of the large bronchi or intrathoracic portion of the trachea and is an indication for immediate surgery. Simple tension or pressure pneumothorax is considered elsewhere. Failure of the lung to expand is an indication of such an injury. Repair of injury to a large bronchus or trachea

may be accomplished by using interrupted sutures to close the laceration and then by reinforcing the suture with a flap of mediastinal pleura. If repair is not feasible, excision of the affected lobe or lung may be necessary. When pulmonary resection is necessary the proximal bronchus is closed with interrupted fine silk suture. If the patient's condition is precarious, proximal mass ligation may be life saving until facilities are available for definitive surgery.

Patients with associated injuries of other organs or parts, for instance, the urinary tract, head, or extremities, which may also require early surgery, will usually be given a better chance for recovery if the thoracic injuries are treated before other operative procedures are undertaken. When there are associated injuries of the extremities, the patient should not be immobilized in a manner which will interfere with coughing and clearing the tracheobronchial tree of secretions.

Cardiac Injuries. The heart may be injured by nonpenetrating, penetrating or perforating thoracic injuries. Contusion of the heart probably occurs more frequently than is realized and, rarely, rupture of one of the cardiac chambers occurs as the result of heavy blows or crushing force over the precordium. However, the great majority of heart wounds are the result of penetrating or perforating wounds. Penetrating wounds often give rise to cardiac tamponade, in which case there may be little actual blood loss. Perforating wounds of the heart usually result in massive hemorrhage into one of the pleural cavities and occasionally to the outside, but in perforating wounds of one of the ventricles, blood may escape from the heart more rapidly than from the pericardial sac, thus producing the picture of cardiac tamponade plus severe blood loss. It is important that this latter situation be recognized at once.

Cardiac tamponade is usually the result of wounds which penetrate the chest wall in the area in which the pericardium is not covered by pleura so that the weapon or missile passes directly through the pericardium and myocardium into one of the cardiac chambers without traversing the pleural space. Blood rapidly fills the pericardial sac and as that structure becomes distended, the opening in the pericardium is displaced away from the opening in the chest wall. As a result there is usually little bleeding to the outside. As the intrapericardial pressure increases, the entrance of venous blood into the auricles is seriously impeded and circulation approaches a standstill.

During this phase, the physical findings are characteristic. The most significant are (1) low arterial pressure, (2) low pulse pressure, (3) high venous pressure (most readily demonstrated by inspecting and palpating the external jugular veins), (4) faint heart sounds, (5) heart rate slow in relation to blood pressure. Fluoroscopic examination shows an apparently immobile cardiac shadow and this confirms the diagnosis of cardiac tamponade.

Initial treatment is as follows: (1) place the patient in moderate Trendelenburg position; (2) give morphine, grain 1/6 to 1/4, and atropine 1/100 to 1/50 grain (if pulse rate is excessively slow, atropine, grain 1/100, should be administered intravenously); (3) administer intravenous fluids as they are of temporary value and should be started at once (5 per cent dextrose in sterile water or, when available, plasma or blood); and (4) perform pericardicentesis, which is by far the most important of the nonoperative measures.

Pericardicentesis is more safely done by the left costoxiphoid route, as the danger of injury to the heart wall, and especially to one of the coronary arteries, is largely avoided. For pericardicentesis by the left costoxiphoid route, a 10 cm., 18-to 19-gauge, short beveled needle should be employed. The skin is punctured by a sharp-pointed knife blade, about 2 cm. below the costal border, adjacent to the xiphoid. The needle is inserted at an angle of 45° to the abdominal wall and passed upwards and backwards for 4 to 5 cm. or until the point seems to enter a cavity. The plunger is gently withdrawn and, if no blood is obtained, a stylet is inserted to be certain the needle is not plugged by tissue. The needle is then carefully passed to a deeper level until blood is obtained or until cardiac pulsations are felt. The removal of even a few ounces of blood is followed by dramatic improvement, which may be persistent or transient. Rarely aspiration will be unsuccessful because of clotting of the blood in the pericardial sac. When this occurs, thoracotomy is usually necessary. If aspiration is successful and there is no recurrence of the signs of tamponade, conservative treatment is continued. If after a considerable lapse of time tamponade recurs, aspiration should be repeated (the needle may be temporarily left in place for this purpose, but only after it has been determined that the point is not in contact with the heart wall). When tamponade recurs rapidly, immediate cardiorrhaphy is indicated.

Surgery of Heart Wounds

Wounds of the heart should be operated upon promptly under the following circumstances:

1. When tamponade cannot be relieved by pericardicentesis because of clotting of blood within the pericardial sac;
2. When tamponade due to failure of the wound to seal off continues or recurs rapidly; or
3. When bleeding into the chest cavity or to the outside continues.

Otherwise heart wounds should be treated conservatively, at least until the operation (including pericardicentesis) can be performed under satisfactory conditions.

Cardiorrhaphy. If differential pressure anesthesia is available, a transpleural approach through a long incision in the third and fourth intercostal spaces anteriorly is preferable. If additional exposure is necessary, the adjacent cartilages may be divided at the sternum. Where proper facilities are not available for differential pressure anesthesia, the operation may be performed extrapleurally under regional block and local infiltration anesthesia. When the latter method is employed, a curved, left parasternal incision is best, and usually three cartilages and segments of the corresponding ribs (three, four and five) are resected subperiosteally. The internal mammary vessels and the corresponding intercostal arteries are ligated and the prepericardial areolar tissue is incised perpendicularly near the sternal border and dissected to the left, carrying the pleural fold with it. The pericardium is opened widely, the blood is removed by suction and the wound is located. Bleeding is controlled by pressure over the wound with the index finger of the left hand and a deep traction suture is passed beneath the compressing finger. Slight traction on this suture will largely control bleeding while the approximating sutures are placed and tied. The traction suture is then removed. Cardiorrhaphy is best done with interrupted sutures of medium, 000 or 0000 silk on a slender curved needle. Apical traction sutures should be employed only when the wound is difficult of exposure. The pericardium is closed with a few widely spaced interrupted sutures. In the presence of excessive cardiac irritability the intrapericardial injection of 10 cc. of two per cent procaine is advisable. Drains are not placed within the pericardial sac.

In rare instances patients with wounds perforating the pericardium and heart will survive for considerable periods. Such cases may lead to confusion and delay because of the combination of signs of cardiac tamponade and massive hemothorax. This combination of findings indicates a grave prognosis, but, if conditions permit, thoracotomy and cardiorrhaphy should be undertaken immediately. The transpleural approach through a long intercostal incision can be executed more rapidly and gives a more adequate exposure for repair of the posterior heart wound.

The presence of foreign bodies per se in the pericardium or heart should not be considered an indication for prompt surgery, the decision whether or not to operate being made on the basis of associated hemorraghe or tamponage.

Cardiac Arrest. Sudden cardiac arrest may occur under a number of circumstances such as after blows over the precordium, during the administration of an anesthetic, following the insertion of an intratracheal cannula when the patient is in a light plane of anesthesia and especially during manipulation of the hilum of the lung or of the heart itself. Spontaneous, unexplained cardiac arrest rarely warrants thoracotomy.

Procaine, one or two per cent (1-2%), infiltration of the hilum of the lung, and the direct application of two per cent (2%) procaine solution to the surface of the heart, may aid in preventing this catastrophe.

When faced with acute cardiac arrest, one must act promptly, for successful resuscitation cannot be achieved if the circulation is allowed to remain in standstill for more than five or six minutes. If the thorax is open, the pericardium should be opened immediately and intermittent cardiac compression begun. If the thorax is not open, a thoracotomy should be performed at once for direct cardiac compression. Delay for the purpose of applying pressure to the heart through the chest wall or diaphragm or for the injection of epinephrine or other substances is apt to result disastrously. If the heart does not respond promptly to direct compression, an intracardiac injection of epinephrine or calcium chloride should be made and intermittently continued until the heart resumes its beat. During this period oxygen should be administered and the lungs expanded periodically (15 to 20 times per minute), preferably through an intratracheal cannula.

CASE DISCUSSIONS

FROM THE LOUISVILLE GENERAL HOSPITAL

Exophthalmic Goiter in Children

Presentation of the Case:

Ji-toong Ling, M.D.

Radioisotope Laboratory

Hyperthyroidism is a complicated hormonal disorder characterized by excessive liberation of thyroid hormone by the thyroid gland. As a rule patients with hyperthyroidism have a goiter, which may be diffuse or nodular. Exophthalmos may or may not be present.

Hyperthyroidism in children is rare, but occasionally occurs at from 10 to 15 years of age, girls being affected about seven times more often than boys. Heredity plays a role in some of the cases.

This patient is an 11 year old white girl. Her father had a subtotal thyroidectomy for exophthalmic goiter and is now on exogenous thyroid, the exophthalmos being unimproved. She was first seen at the Radioisotope Laboratory in January, 1954, presenting a history of increasing enlargement of the neck, prominent eyes, occasional diarrhea, weakness, heat intolerance, nervousness, sweating, exertional dyspnea, palpitation, increased appetite and weight loss all of a six months' duration. For five months she had taken 30 drops of Lugol's solution per day without any apparent improvement.

Physical examination revealed a well developed but rather thin, stimulated girl with a large diffuse goiter estimated to weigh approximately 120 (gm). No bruit was heard over the gland. Other physical findings of significance were a warm, moist skin, tachycardia of 136 per minute, marked tremor, and moderate exophthalmos (Fig. 1).

Laboratory studies showed a basal metabolic rate of + 89. A tracer dose of 50 microcuries of radioactive iodine revealed an uptake of 98 per cent in 24 hours, the normal range being from 15 to 45 per cent. This was corroborated by a 18.28 per cent urinary excretion.

Dr. Melick, will you discuss the medical management of diffuse exophthalmic goiter with anti-thyroid drugs?

Dr. Roger Melick:

Department of Medicine

In a study of 220 anti-thyroid compounds, Astwood and associates found propylthiouracil, thiouracil and thiobarbital most effective. Recent experience with propylthiouracil as reported by Astwood, and Lahey and Bartels, indicates that propylthiouracil is far superior to thiouracil, the toxicity of thiouracil being much greater than that noted with propylthiouracil.

Since Astwood reported the occurrence of sustained remissions, and the possibility of permanent cures resulting from thiouracil, attention has been focused upon the incidence of these remissions and the risk involved in therapy. In most patients treatment with thiouracil, at least six to nine months was needed to produce remissions of longer than three months duration, patients treated for shorter periods showing a high incidence of relapse. Prolonged therapy does not necessarily produce permanent remission as is shown by the observations of Williams,



Figure 1

who reported relapses after 18 to 21 months of treatment. No definite statement can be made as to the time required to insure permanency of remission in any given case. Patients with mild toxicity will have sustained remissions more often than will patients with a severe degree of thyrotoxicosis. Experience indicates that one may expect permanent remissions in about fifty per cent of patients treated.

The patient under discussion did not have a therapeutic test with propylthiouracil or thiouracil. However, in view of her severe toxicity, I doubt whether a sustained remission could have been obtained with the above type of medication alone. She had received Lugol's solution for almost five months with no clinical improvement.

Dr. Lynn, we would like to hear the surgeon's opinion in regard to the management of thyrotoxicosis in this age group.

Dr. Hugh B. Lynn:
Department of Surgery

Thyrotoxicosis in this age group is so uncommon that no one physician has much experience with the problem. Cases of this type are generally treated by resection; with due awareness of the shortcomings of the procedure and its attendant risks and complications. The results, by and large, have been satisfactory. I personally have been very little impressed with the regression of exophthalmos following surgery and the more disappointing of these results appear always to be in young women. Though surgery definitely has something to offer this patient, in an eleven year old child any "simpler" method of therapy should be strongly considered. The use of radioactive iodine is still in its infancy, and only time will tell whether this will replace thyroidectomy in this age group.

Dr. J. T. Ling:
Radioisotope Laboratory

Dr. Kerman, will you discuss the use of radioactive iodine in the treatment of diffuse toxic goiter versus anti-hyperthyroid medication and thyroidectomy?

Dr. Herbert D. Kerman:
Radioisotope Laboratory

The use of radioactive iodine is an outgrowth of the observation of Means and Holmes that X-ray radiation of the thyroid will cure a significant number of patients with hyperthyroidism. Because the thyroid takes up iodine selectively, radioiodine when administered orally will be retained in the thyroid gland. Within the gland its radiations are liberated and produce a greater radiation effect than that derived from X-rays delivered through the skin and overlying tissues, without the possible complications of X-ray.

The simplicity of administering radioiodine and the physiologic selectivity of irradiation surpass either the prolonged use of antihyperthyroid drugs or a major surgical procedure. It is effective by mouth and its use is rarely attended by any serious reaction. Complications are extremely few and none is serious.

In patients with diffuse toxic goiter radioiodine will induce a permanent remission in fully as high a percentage of patients as will a subtotal thyroidectomy without the possible attendant complications of surgery. Seed and Jaffe reported sustained remissions in 80 per cent of 1,720 cases contained in the literature. In the same group, hypothyroidism occurred in only 9 per cent, with no other complications and no recurrences. The incidence of hypothyroidism can be much lowered by using divided dose administration of radioiodine rather than a large single dose.

The primary reason that radioiodine therapy has not completely replaced subtotal thyroidectomy in the treatment of exophthalmic goiter particularly in the younger group is that it has not yet been determined whether radioactive iodine influences the development of carcinoma of the thyroid in later years or affects growth or produces gonadal injury. The data available up to the present time indicate that it does not, but many more years may have to elapse before definite conclusions concerning this can be drawn. At present the possible genetic injury and carcinogenic effect in the above use of Radioiodine in humans remain purely hypothetical possibilities.

Radioiodine has been used extensively for at least 12 yrs. and it is estimated that well over 5000 cases have been treated. There is yet to appear in the literature, to the best of my knowledge, a single instance of carcinoma of the thyroid occurring in an individual who had received therapeutic amounts of radioiodine for the treatment of hyperthyroidism. During the early years of Radioiodine treatment most clinics were quite conservative in treatment of younger patients, but at the present time more and more are treating hyperthyroidism at any age.

Although it is said that irradiation is more effective in relieving exophthalmos, statistically there is little difference in the

results with surgery, X-radiation or radioiodine.

Dr. J. T. Ling:

Radioisotope Laboratory

Dr. Christopherson, will you further elaborate the possibility of carcinogenic effect in the radioiodine management of exophthalmic goiter in the younger age group?

Dr. Wm. M. Christopherson:

Dept. of Pathology

Ionizing radiations are known to be carcinogenic for a variety of tissues in several mammalian species, including man. There is perhaps no other class of external agents with such a universality of carcinogenic effectiveness.

Goldberg and Chaikoff encountered seven carcinomas of the thyroid similar to those found in humans in a group of twenty-five rats receiving single intraperitoneal injections of 400 Mc. of I^{131}. No cancer was found in a control group of 125 rats on goitrogen feedings. It should be stressed that intense or prolonged local irradiation, followed by a relatively long latent period, is necessary to produce these experimental tumors. However, there is, to my knowledge, as yet no data indicating that thryoid carcinoma has been produced in man by I^{131}. It also should be noted that the dosage of I^{131} used by Goldberg and Chaikoff was of a considerably greater magnitude than the dosage used therapeutically in hyperthyroidism. My own feeling is that it is necessary to weigh the possibility of untoward side effects of I^{131} against its usefulness and against the effectiveness of other modalities.

Dr. J. T. Ling:

This patient was given 4 mc. of radioactive iodine orally in January, 1954, and began to show clinical response after about five weeks. When she was last seen in July, she had gained 28 pounds in weight and clinically the thyroid was functioning normally. The thyroid is now felt to be slightly larger than the normal average. Her exophthalmos persists although there is less prominence than before. (Fig. 2). The pulse rate is 100 per minute. On July 27, 1954 a thyroid uptake study following an oral tracer dose of 40 mc. of radioiodine was 24.3% in 24 hours.



Figure 2

One of the AMA's severest critics, radio news commentator Frank Edwards, was dismissed by his sponsor, the American Federation of Labor, for oversalting the news with opinion and failing to keep news and opinion separate, according to an announcement by George Meaney, AFL president. Harry Flannery, former radio commentator, will replace Frank Edwards, Mr. Meany said.

Five past presidents of the AMA, including two KSMA members who held this distinguished honor, died during the past year. Between the Annual Meeting in New York in June, 1953, and the San Francisco session in June 1954, the following passed away: Frank H. Lahey, M.D., Boston, Elmer L. Henderson, M.D., Louisville, Edward H. Carey, M.D., Dallas, James S. McLester, M.D., Birmingham, and Fred W. Rankin, M.D., Lexington.

The late Andrew B. McGraw, M.D., Detroit, Michigan, bequeathed $5,000 to the American Medical Education Foundation. The foundation reports this as the first such legacy awarded the AMEF since its inception in 1951.

The American Goiter Association is again offering the Van Meter Prize Award of $300 and two honorable mentions for the best essays not to exceed 3000 words, submitted concerning original work on problems related to the thyroid gland. Essays may cover either clinical or research investigation. For complete details contact your KSMA Headquarters Office.

SPECIAL ARTICLES

THE DETECTION OF DIABETES: THE POSITIVE URINE TEST FOR SUGAR

JOHN S. LLEWELLYN, M. D.

Louisville

This year National Diabetes Detection Week is scheduled for November 14 to 20 and the Kentucky State Committee under the direction of Doctor Carlisle Morse, Governor of the American Diabetes Association, together with the County Society Committees are preparing for the detection of the many unknown diabetics. Last year in Kentucky 35,384 urine tests were made during Diabetes Detection Week and 695 of the tests were positive for sugar. Of this number 224 were proved to be due to diabetes mellitus. The total number of tests performed represents a very small percentage of the state's population and the committees hope to test a far greater group this year.

All persons having a positive urine test during the week will be notified immediately and urged to seek the advice of their physician. The responsibility of the physician is to establish the cause of glycosuria and to institute the indicated therapeutic regime.

As is the case in any medical problem the person with a positive urine test for sugar should have a thorough and detailed medical interview and a searching physical examination. In each of these there are often diagnostic clues of as great value as an abnormal blood sugar. A family history of diabetes, a long tendency to obesity, and in the female the failure to conceive, menstrual irregularities, frequent miscarriages, toxemia, stillbirths, or a history of the birth of larger than normal babies are most suggestive of diabetes or potential diabetes. A history of recurrent pyelitis and cystitis, impotence, and pruritus may be as important as the classical history of polyuria, polyphagia, polydipsia, and weight loss. Evidence of premature vascular degeneration is of extreme importance since it is as characteristic of diabetes as is the glycosuria and hyperglycemia. Even a rare finding such as calcification of the vas deferens is considered pathognomonic of diabetes.

In most cases glycosuria is due to diabetes mellitus although alimentary glycosuria, abnormally low renal threshold for glucose, hyperthyroidism, and the relatively uncommon melliturias must be eliminated as possible causes. In establishing the diagnosis of diabetes and determining to some extent its severity one must use blood sugar determinations. The fasting blood sugar is of little value as it has been shown that mild diabetics, especially the "maturity onset" group, have adequate amounts of endogenous insulin (determined by plasma insulin assay) to reduce abnormal postprandial hyperglycemia to normal levels in 6-8 hours. The more accurate determination for decreased carbohydrate tolerance is the glucose tolerance test or one of the simpler and more easily performed modifications.

A blood sugar determination done 1 to 2½ hours after a meal of normal carbohydrate content should be normally 170 mgm.% and 120 mgm.% or less respectively, and values greater than these figures are proof of diabetes. Another useful modification of the tolerance test consists of blood sugar determinations 1 and 2½ hours following the ingestion of 100 grams of glucose. This procedure affords the two more important criteria of a tolerance test (one hour peak and duration of hyperglycemia) and the normal values are identical to the values for the post-prandial determination. It is only in borderline or doubtful cases that the oral or intravenous glucose tolerance tests are necessary.

A word of caution is indicated for the case with an initial positive urine sugar failing to show glycosuria in subsequent tests and blood sugar levels falling in the non diabetic classification. Such patients should be observed carefully in the future and apprised regarding the value of carbohydrate restriction and maintenance of normal weight. A single episode of asymptomatic glycosuria may not be as innocuous as previously believed: 29% of a large series of hospitalized patients with such a finding developed diabetes in the succeeding 10 years.

Once the diagnosis of diabetes is established treatment should be instituted early and in an aggressively vigorous fashion. An attempt should be made to achieve aglycosuric normoglycemic control as nearly as possible and at the same time avoid hypoglycemic episodes which, if frequent or severe, can be as deleterious as poor control. There is no better stop-gap to the development of any complication of diabetes than adequate control of the altered carbohydrate tolerance. Although selective emphasis may have shifted in past years the basic principles remain diet, insulin and exercise.

Diet therapy should be emphasized in all cases but especially so in the mild diabetic whose control is to be effected without the use of insulin. Dietotherapy has been simplified in recent years without sacrificing accuracy by the introduction of the Exchange Method which employs household measures and lists of similar foods having like caloric value. The lists are as follows:

1) Milk exchanges—C 12 grams, P 8 grams, F 10 grams, 170 calories
2) Vegetable exchanges A—contains little C, P, or F
3) Vegetable exchanges B—C 7 grams, P 2 grams, 35 calories
4) Fruit exchanges—C 10 grams, 40 calories
5) Bread exchanges—C 15 grams, P 2 grams, 70 calories
6) Meat exchanges—P 7 grams, F 5 grams, 75 calories
7) Fat exchanges—F 5 grams, 45 calories

By this simple method an adequate diet can be individualized according to the patient's needs. It is easily explained to patients and is more quickly understood than the complicated diets employing percentages, calories, and time consuming weighing of foods.

The daily basal caloric requirement may be obtained by multiplying the ideal weight of the patient by 10 and adding 100-300 calories for the "growing" patient or for those whose daily activities are more than ordinary. Deducting 100-300 calories from the basal daily total is in order for those who are overweight. The carbohydrate in the diet should be moderately restricted and the protein allowance slightly higher than usual since this element aids in stabilization and prevention of hypoglycemia. Sufficient fat is allowed to make up the remainder of the total calories.

Sample exchange diets ranging from 1200 to 2500 calories have been prepared by one of the leading pharmaceutical firms and are available to physicians without charge. A small booklet of 19 pages is also available for a nominal charge from the Health Publications Institute of Raleigh, North Carolina. In this valuable booklet a page is provided for the diet prescription and on subsequent pages the several exchange lists are explained pictorially and outlined in simple detail. It also contains several pages of useful recipes including desserts.

With insulin therapy it is best that the patient be taught to test the urine before each of the three meals and to administer regular insulin according to the degree of glycosuria (3-6 units for each plus of glycosuria). In this way the patient is indoctrinated in syringe and needle sterilization and injection technics. After 4-7 days it is usually possible to determine daily average insulin requirements and one of the repository insulins can be given once daily before breakfast. NPH Insulin is generally conceded to be the repository insulin of choice and should be started in dosages 75% of the total average dose of regular insulin.

The adequacy of diabetic control may be determined by employment of both fasting and post-prandial blood sugar levels. A fasting blood sugar for a diabetic on a repository type of insulin should be 120-160 mgm.% and 2½ hours post-prandially blood sugar levels of 160-200 mgm.% are acceptable depending on the individual and the susceptibility of late post-prandial hypoglycemic reactions. NPH Insulin lends itself well to tailoring of dosage with regular insulin and mixing does not influence the time action of either.

Once regulated, the diabetic should be instructed regarding exercise and this is particularly true in juvenile diabetics who are typically labile and exercise violently. Exercise should be avoided or curtailed during periods immediately preceding meals when blood sugar levels are low. Occasionally small mid-meal carbohydrate and/or protein feedings are necessary and anyone on a repository type of insulin should have a bedtime feeding high in protein content to maintain blood sugar levels during the nocturnal period of fasting.

For the control of diabetes primarily there are adequate implements—diet, insulin, and exercise, but for the many complications such as premature vascular degeneration and neurological disturbances there is little save strict control of the carbohydrate intolerance. The key to early control is early detection.

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EDITORIALS

"MAGIC DRUGS" IN PSYCHIATRY

In recent months there has been great emphasis in both medical and lay press on new drugs which are said to be revolutionizing the treatment of neuro-psychiatric conditions. These agents are presented as the expected concomitants of the anti-biotic age, the magic drugs of psychiatry. Holding the spotlight at present are the highly touted chlorpromazine (Thorazine) and the hoary but rediscovered Rauwolf (Serpasil). A neophyte exposed to the carefully edited copy of the detail man, the most encouraging but uncontrolled reports in the medical literature and the flamboyant writeups in the lay press might indeed think that the millennium is upon us. One can even understand how the more experienced practitioner, harassed by the average group of inadequate, frustrated and anxious people who fill his waiting room might adopt these measures with more hope than discernment.

This enthusiasm for the new is an old pattern in medicine and especially through the years has it been applied to the ills of mankind for which least specific remedies have been available. In no branch of medicine have there been more varied and enthusiastically accepted but short-lived and unproven therapies than for the common emotional symptoms of stress. Fifty years ago trephining was in great vogue in the leading medical clinics as accepted treatment for all emotional disturbance. We are but a few years away from the rather wholesale removal of teeth, tonsils and prostate as well as long sections of the gastro-intestinal tract in a vain attempt to remove microscopic foci of infection and prevent auto-intoxication as a routine treatment of schizophrenia. The preliminary reports on those methods of treatment were as encouraging and optimistic as ones we are encountering today.

In psychiatry as in medicine generally great progress has been associated with outstanding developments along specific lines. Thus the interest in and contributions to the treatment of general paresis followed almost immediately upon the introduction of the Wasserman test and the work of Nagouchi and Moore. Similarly the basic development in psychotherapy and mental hygiene followed closely on the fundamental contributions of Freud and Myer. The major achievements of the last few years have again swung back toward the organic with the introduction of the shock therapies and psychosurgery. During the last twenty years we have had persistent and varied reports concerning promising results in the treatment of mental ills with a wide variety of therapeutic agents. Some of these treatments have continued to be used with reported success in certain clinics, but with equivocal findings elsewhere (e.g., ACTH and cortisone, thyroid by the Milwaukee group, CO_2 inhalations by Meduna). Others have found a limited but specific value (e.g., various forms of sleep therapy, histamine and nicotinic acid in arteriosclerosis, amphetamine and barbiturate combinations in management of depressive reactions, antabuse therapy in alcoholism). Many more have been generally discarded (e.g., ether and N_2O inhalations, estrogen and testosterone, the antitubercular drug, isoniazid, histamine injections, mephenesin (Tolserol)).

However, in recent months two therapeutic agents have been recommended as almost panaceas in the treatment of a wide variety of psychiatric conditions. Both tend to act on the higher vegetative centers in the midbrain and diencephalon. In the hierarchy of nervous organization, the grosser and simpler reflex actions are relegated to the cord while the complex intellectual functions are mediated by the cortex. Interposed between are the higher vegetative centers with their complex and intricate connections that integrate the unconscious emotional patterns with the intellectual properties of the cortex. It is within these subcortical centers that the derangements and deficiencies that produce emotional disturbances are said to lie.

Chlorpromazine (Thorazine—SKF) developed in France was originally intended for the use in the management of general anesthesia or severe wound shock. "Its action is described as vagolytic, sympathicolytic, spasmolytic, and anti-pyretic anti-emetic and sedative with a potentiating effect on other hypnotic, narcotic anesthetics and analgesics." Mainly a vege-

tative inhibitor and to a lesser extent a sedative it has been applied to all conditions in which a vegetative disturbance plays a part, such as anxiety states, severe neuroses, schizophrenia, manic-depressive reactions, acute withdrawal reactions following addiction and various psychosomatic conditions. Available for oral or parenteral use, it produces somnolence, lethargy or actual sleep, "seems to reduce all action tendencies whose origin and maintenance are dependent on feelings—it is one of the most powerful sedatives known." It is reported as particularly valuable in the agitated arteriosclerotic or senile patient. Reported complications include undetected infection (because of the low body temperature produced) occasional syncope due to orthostatic hypotension, gastro-intestinal disturbances, dryness of the mucous membranes, particularly of the upper respiratory tract with an increased susceptibility to infection, allergic reactions and a disturbance of liver function in 3 to 5% of the cases, manifested as a benign jaundice. "Treatment with the drug is best administered in a hospital since attentive nursing and carefully adjusted dosage and timing are essential." Severe side reactions (especially dizziness and blackouts) have occurred which confirm the advisability of this quotation.

Reserpine (Serpasil-Ciba) is a pure crystalline alkaloid of rauwolfia root widely used in Ayurvedic (Indian) medicine for centuries for a variety of conditions. It has recently come into prominence as an anti-hypertensive agent and has also been recommended as a "tranquilizing" factor relieving anxiety, tension, irritability, insomnia, depression, etc., but allowing patients to retain their drive and energy. The tranquilizing and hypotensive effect are said to result "from the protective action on the central autonomic centers against stimuli coming in from peripheral and even the cortical area." Another investigator ascribes its effects to partial suppression of sympathetic dominance at the hypothalamic level. No serious toxic reactions have been reported. However, as gastric secretion is said to be stimulated by this drug, caution is advised with its use in ulcer or potential ulcer patients. Other side reactions such as nasal stuffiness, occasional gastro-intestinal symptoms, headache, bizarre dreams and dizziness have been reported.

These reports are most encouraging to both general practitioners and psychiatrists as they give promise of a simple answer to a variety of frustrating patients who have successfully thwarted our efforts for years.

But why do we pause?

Perhaps we remember other startling innovations, the first enthusiastic reports, the later better controlled and documented studies with the first trickle of toxic reactions. The impetuous use of new drugs carries two possible dangers. First, a physician by the improper use of such a drug may delay or deny temporarily or critically to his patient definitive treatment rendering his illness more serious or resistant to later treatment. Secondly, he may expose his patient to a drug which has been inadequately evaluated in a setting where proper follow-up and safeguards are practical, thus taking a risk which is greater than the possible gain in the case involved. A neuro-psychiatric disorder may be aggravated into more serious one as for example, the paranoid psychoses sometimes precipitated by the injudicious use of amphetamine. One is left with the feeling that as a private practitioner in medicine the preliminary reports of such therapeutic agents should be followed with interest but that these agents should not be used on private patients unless a real life saving measure is involved. The sound physician is the conversative one who "is not the first by whom the new is tried" but rather one who leaves the establishment of the therapeutic efficacy of such new approaches to the endowed clinics best able to evaluate and who can follow closely and safeguard the guinea pigs involved.

Especially should these things be considered in the new pharmacological approaches for emotional conditions. For example, Thorazine is said to cause temporary and reversible liver dysfunction. That liver disease and emotional disturbances are variously and inexplicably related has been well established. Who is in a position to say when liver dysfunction is completely reversible? Serpasil, on the other hand, must be used with caution in the presence of peptic ulcer. In an anxious or emotionally disturbed patient, how comfortable can we be about the integrity of the duodenal mucous membranes, with or without X-ray studies? Who can say what late bone marrow effects may appear?

The basic question each of us must decide is how much more does this have to offer to this particular patient with an emotional (usually non-fatal) disorder which will justify choosing it over another approach whose toxicity as well as its limitations are well established.

JOHN P. BELL, M.D., Louisville

President's Page

The House of Delegates of the Kentucky State Medical Association has given me the most responsible assignment it has been my honor to receive, and for their confidence, I am humbly grateful. At the same time, I am cognizant of the fact that our organization will not solve its problems and carry out its dedicated purposes set by the elected delegates without the cooperation of the component societies and our individual members. This, I beg of you, to provide to the fullest.

First, we would like to pay respect to J. Duffy Hancock, M.D., our immediate past president, for his unselfish, devoted attention to the affairs of organized medicine in Kentucky.

Some things that compel attention at this time are:

1. Our purposes and policies, both scientific and organizational in nature, so carefully arrived at by the elected delegates, are of little more local value than the component units wish to make them.

2. We should increase our efforts to promote the idea that the securing of a physician is the personal responsibility of the individual patient or family, and with rare exceptions, this responsibility should not be delegated to a third party.

3. Our responsibility in improving our scientific and technical knowledge which is reflected in better care of our patients should continue to occupy the highest position in our organization.

We all realize that although our abstract decisions and policies must be made through our duly elected representatives, that the light in which our organization is held and the principles for which we stand to a great degree is determined in the minds of our patients by what happens between the individual physician and his patient.

L. C. Sparks

PRESIDENT

ORGANIZATION SECTION

'Support the 1954 Diabetes Drive Nov. 14-20,' Chairman Urges

Full participation by every KSMA member in the 1954 Diabetes Detection Drive, November 14 to 20, has been requested by the KSMA Diabetes Committee through its chairman, Carlisle Morse, M.D., Louisville.

It will be the fourth consecutive year in which the KSMA has sponsored the statewide campaign to discover some 15,000 unknown diabetics. It is conducted in conjunction with the American Diabetes Association as a part of National Diabetes Week.

Each physician is asked to give a free urine sugar test to all persons requesting it between November 14 and 20. A free supply of testing materials is available to the physician through his county medical society diabetes committee.

The national program of the American Diabetes Association is the only prominent activity of this nature which is directed and controlled entirely by the medical profession. It is distinguished by the fact that it engages in no general fund raising campaign.

The American Diabetes Association has singled out the work of Kentucky in diabetes detection. It is the only state in which the campaign is organized on a statewide basis under medical association sponsorship.

Dr. Morse reports that approximately 100 county medical societies have indicated that they and their members will participate in the drive this year. These societies have named their diabetes committees and are already perfecting arrangements for the 1954 campaign.

"The success of the Diabetes Detection Drive in Kentucky, which reached new heights in last year's campaign, is a tribute to the cooperative attitude and public spirit of Kentucky's individual physicians," Dr. Morse said.

"The members of the county medical society diabetes committees, on whose shoulders falls the chief responsibility for thorough implementation of a program such as this, have done an outstanding job that has become better every year.

"Additional public acceptance of this program and demand for it has been steadily increasing as the people better understand the hopeful future that awaits the diabetic who knows he has the disease. It may be expected that the thousands of persons who saw the KSMA exhibit on diabetes at the recent Kentucky State Fair will give it further impetus."

The Diabetes Detection Drive was first held in 1951. More than 35,000 free urine sugars were provided to the public last year and 288 persons were reported as newly discovered diabetics.

Other members of the KSMA Diabetes Committee in addition to Dr. Morse are: Herald K. Bailey, M.D., Ashland; Charles B. Billington, M.D., Paducah; George N. Burger, M.D., Covington; Guinn S. Cost, M.D., Hopkinsville; Marcus A. Coyle, M.D., Springfield; Frank H. Moore, M.D., Bowling Green; Franklin B. Moosnick, M.D., Lexington; William R. Parks, M.D., Harlan, and Stanley Simmons, M.D., Louisville.

"Ky. Nurses Week," Oct. 11-16 Highlighted by Tribute Dinner

"Kentucky Nurse Week" will be observed concurrently with National Nurse Week, October 11-16, 1954, according to an announcement from the Committee on Careers in Nursing of the Kentucky League of Nurses.

Highlight of the week will be a tribute dinner at the Kentucky Hotel, Louisville, on Saturday, October 16. The program will include recognition of Kentucky's most outstanding nurse and an address by a nationally known speaker.

For further information contact Mrs. Jerry A. Lloyd, 1162 Eastern Parkway, Louisville 5, Kentucky. The Careers Committee will welcome the participation of all nurses in carrying out the activities of Kentucky Nurse Week.

Technical Exhibitors Thanked for Contribution to Annual Meeting

The Committee on Technical Exhibits wishes to express its sincere appreciation to each of the 60 technical exhibitors who helped finance the KSMA Annual Meeting through rentals paid for booth space and who contributed much information of value to members with their attractive displays explaining the latest medical and technical developments.

Carlisle R. Petty, M.D., Louisville, chairman of the committee, was well pleased with the splendid interest and support given the techni-

cal exhibits by the KSMA membership. He added that the growing cooperation between the two groups acts as a stimulus in attaining the goal of establishing the KSMA Annual Meeting as among the best of the smaller state associations.

"The hundreds of dollars it costs each company to exhibit with us at the KSMA Annual Meeting each year can only be compensated by the amount of interest members show at the booths," the chairman said.

Following is the list of exhibitors:

Abbott Laboratories
A. S. Aloe Company
Ames Company, Inc.
Audio-Digest Foundation
Ayerst Laboratories
Bilhuber-Knoll Corporation
Blue Cross Hospital Plan, Inc.
The Borden Company
George A. Breon & Company
Burroughs Wellcome & Company, Inc.
Central Dairy Council
The Central Pharmacal Company
The Chicago Pharmacal Company
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The Coca-Cola Company
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Doho Chemical Corp.
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Zimmer Manufacturing Company

Applicants to U. L. Med. School Decrease for 7th Year

A downward trend in the number and quality of applicants has continued for the seventh consecutive year at the University of Louisville School of Medicine where the situation is typical of the national pattern, it was pointed out in the August 15 issue of the Louisville Courier-Journal.

J. Murray Kinsman, M.D., dean of the medical school, cited in figures the changing trend: applicants for a freshman class of 100 in 1948 totaled 430, in 1954, applicants totaled 215.

An important reason Dr. Kinsman gave for this serious situation is that freshmen enrolled in medical school at present were born during the depression years when the birth rate fell sharply. Another important factor in the decline is the fact that the peak of the GI Bill for educational activity coincided with the peak in number of applications to enter medical schools.

S. I. Kornhauser, M.D., professor of anatomy at the University of Louisville School of Medicine, suggested a number of reasons why acceptable candidates are not applying for entrance to medical schools.

These include: the curriculum is too strenuous, other scientific fields offer lucrative reward, large industries are attracting many college students with scientific minds and offering attractive pay at the start, medical school tuition is expensive, and students are fearful of government intervention into the private practice of medicine.

Nashville Medical Assembly Meets

The Nashville Medical Assembly will hold its seventh annual session in cooperation with the Tennessee Academy of General Practice October 28-29, 1954, at the Hermitage Hotel, in Nashville, Tennessee. Fourteen guest scientific speakers will appear on the program, sponsored by the TAGP and Davidson County Medical Society.

Presidential Appointees Named For KSMA Committees

Presidential appointees to KSMA Committees for the 1954-55 year have been announced by Clyde C. Sparks, M.D., Ashland, who took office as KSMA president during the Annual Meeting in September.

In order that committees may continue with present programs already underway and proceed with new plans for the coming year, an effort was made to announce the personnel of the committees at the earliest possible date.

Committees appointed by the Council will be listed in the November Journal. The 1954-55 presidential committees are as follows:

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William H. Barnard, Elizabethtown
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Group Formed to Promote Interest In U.K. Medical School

The Kentucky Medical Foundation, a new organization, was formed in Lexington during September to promote the establishment of a state supported medical school at the University of Kentucky, according to published report.

A group of 34 medical, business, farm and civic leaders from throughout Kentucky comprise the membership of the Foundation. J. Stephen Watkins, Lexington, former state highway commissioner, was elected temporary chairman.

The Foundation will incorporate as a nonprofit, charitable corporation authorized to accept gifts from any source to further its objectives. The temporary chairman named two committees, a nominating committee and a bylaws committee. Francis Massie, M.D., Lexington, was named chairman of the nominating committee.

Federal Medical Officers Needed

Positions for Medical Officer and Medical Officer Specialist are now open in various federal agencies in Washington, D.C., throughout the U.S., and the Panama Canal Zone, according to a recent announcement from the U. S. Civil Service Commission. No written test is required for these positions. Full details may be obtained by contacting your KSMA Headquarters Office, 620 South Third Street, Louisville, Kentucky.

KSMA Surgeons Participate in ACS Clinical Session

Several KSMA surgeons will participate in the scientific program of the 40th annual Clinical Congress of the American College of Surgeons, to be held in Atlantic City, New Jersey, November 15 to 19, it has been announced by M. J. Henry, M.D., Louisville, president of the Kentucky Chapter.

Charles F. Wood, M.D., Louisville, will participate in a Symposium on Trauma, "Fractures in Children," on Tuesday, November 16. R. Arnold Griswold, M.D., Louisville, will preside over the afternoon meeting.

President of the ACS, Frank Glenn, M.D., New York, will preside at the opening evening session, at which Alan Gregg, M.D., and Robert H. Kennedy, M.D., both of New York, will be guest speakers. On the final evening, Alfred Blalock, M.D., Baltimore, will be installed as president for the coming year.

Annual Meeting Tape Recordings Made by Indiana Ass'n

The Committee on Medical Education and Hospitals of the Indiana State Medical Association made tape recordings of the scientific program of the KSMA Annual Meeting, September 21, 22, and 23, according to J. Duffy Hancock, M.D., 1953-54 president, who granted the permission.

The recordings will be used by Indiana county medical societies and individual members. In the past three years, the Indiana group has collected more than 200 hours of tape recording which it has on loan. An average of 85 to 100 tape recordings a month are requested.

'Seminar on Rheumatic Diseases' To Be Held October 28

The Kentucky Chapter of the Arthritis and Rheumatism Foundation and the University of Louisville Postgraduate Seminar will co-sponsor a "Seminar on Rheumatic Diseases," at an all day meeting October 28, to be held at the Louisville General Hospital Amphitheatre.

According to R. L. McClendon, M.D., Louisville, chairman of the Medical Committee of the Kentucky Chapter, featured speaker at the 8:00 p.m. evening session will be Russell Cecil, M.D., New York City, national medical director of the Arthritis and Rheumatism Foundation. "Problems of Rheumatoid Arthritis" is the subject of Dr. Cecil's discussion.

During the day, nine clinical discussions and papers will be presented. Appearing on the program will be J. Murray Kinsman, M.D., dean of the University of Louisville School of Medicine; Lawrence T. Minish, Jr., M.D., David Shapiro, M.D., George W. Pedigo, M.D., William N. Christophersen, M.D., Rex McMorris, M.D., and Kenton D. Leatherman, M.D., all of Louisville.

After lunch there will be a tour of the Louisville Rehabilitation Center, Dr. McClendon said. All physicians and medical students are cordially invited to attend this all day session for which there is no charge, he concluded.

AMA Reports Time Change in Two Medical Telecasts

The dates of two nationwide medical television programs, "The Doctor" and "March of Medicine" have been changed from the originally scheduled times published in the September issue of "AMA News Notes."

"The Doctor," to be presented on the "Cavalcade of America" program, can be seen over 75 stations of the ABC-TV network on Tuesday, December 7, instead of November 9.

The first program in the "March of Medicine" series will be telecast October 31 instead of October 24 at 4:30 p.m. CST over some 60 stations of the NBC-TV network.

SMA to Hold 48th Meeting

Final plans have been completed for the forty-eighth Annual Meeting of the Southern Medical Association to be held in St. Louis, Missouri, for the fifth time, November 8-11, 1954, according to Alphonse McMahon, M.D., St. Louis, president.

One hundred and four years of organization and achievement provide a fine background for further education and entertainment of the November meeting. Requests for room reservations should be sent to the Housing Bureau, Southern Medical Association, 911 Locust Street, Room 406, St. Louis 1, Missouri.

WMA Conducts Membership Drive To Ease Financial Plight

KSMA physicians are asked to join in a renewed membership campaign for the World Medical Association which is in need of immediate financial support to build up a depleted treasury, according to Louis H. Bauer, M.D., New York, secretary-treasurer of the U.S. Committee.

"The World Medical Association is the only international organization which can and does speak from the non-governmental standpoint and from the standpoint of free enterprise," Dr. Bauer pointed out. "However, it can only continue to defend your interests if it has adequate financial support."

The membership fee is ten dollars. Application blanks can be secured from Louis H. Bauer, M.D., World Medical Association, 345 East 46th Street, New York 17, New York.

AMA Urges Societies to Offer Intern-Resident Membership

Attention has been called to the large county medical societies in which are located teaching hospitals that the KSMA offers interns and residents membership running from September 1, to that date the following year, for a fee of five dollars.

George F. Lull, M.D., secretary and general manager of the AMA, in his "Secretary's Letter" points out that there are 7,000 new graduates and 20,000 serving internships and residencies. He urges all states to provide for the inclusion of these men in organized medicine.

Nurses Hold Workshop Oct. 28-29

A workshop on ward management will be held October 28 and 29 at the Seelbach Hotel in Louisville by the Steering Committee of the Kentucky League of Nurses Division of Nursing Service, according to Miss Kathryn B. Ernstes, Louisville, president of the League.

Sister James Marian, assistant director of Nursing Service, St. Joseph Infirmary, Louisville, is chairman of the Steering Committee. Mrs. Ardis Merrilees, Veterans Administration Hospital, Louisville, is chairman of the program committee for the workshop.

"Yale Success Story Published"

A report on the first thirty years of the "Yale Plan of Medical Education," written by Vernon W. Lippard, M.D., dean of the Yale University School of Medicine, appeared in the September issue of the Journal of Medical Education.

Under the Yale program, the medical student is treated as a graduate student and given more than customary responsibil'ty for his own development. Four characteristics of the program are: a required dissertation, lack of fixed course requirements for qualified students, emphasis on elective courses and the absence of required course examinations.



Newest addition to the Cincinnati Sanitarium is the Harry Peers Collins Memorial Pavilion.

Cincinnati Sanitarium Opens New Electroshock Therapy Building

Special emphasis has been placed on creating a home-like atmosphere at the Cincinnati Sanitarium's new building for the exclusive use of ambulatory out-patient electroshock therapy. Known as the Harry Peers Collins Memorial Pavilion, it was erected as a memorial to the president and guiding hand of the Sanitarium for 45 years.

The new building includes 14 treatment rooms, physicians' consultation room, reception room, and equipment room, as well as a shaded patio and picnic area with a grill. The lower level contains a new occupational therapy department and a large, well-equipped recreation area.

Carefully designed to minimize the apprehension and anxiety of patients awaiting treatment, the building does not have the appearance of a hospital. A mobile unit containing the electroshock equipment has been devised which can be rolled up to the patient's door and remain out of sight. Only the needed attachment is unobtrusively brought into the room itself.

New Medical Building Planned

A new $50,000 medical office building, which is to include physicians' offices, laboratory, X-Ray facilities and a private pharmacy, is being constructed in Shively, according to published report.

Entire facilities of the building will be leased to physicians. Fred B. Kluth, Louisville, owner of the Louisville Apothecary, said he hoped the building would be erected by the end of the year.

Dr. Bosworth Speaks in Louisville

Joseph M. Bosworth, M.D., Atlanta, Georgia, was the featured guest speaker at an Industrial Health Luncheon, sponsored by the KSMA Committee on Industrial Medicine and Surgery and the Industrial Medical Association, held September 21, 1954, according to Chairman Gradie R. Rowntree, M.D., Louisville. "What Is the Doctor Worth to Industry?" was the subject of Dr. Bosworth's discussion.

Blue Cross-Shield Sponsor Program

Blue Cross and Blue Shield are now sponsoring the radio program, "Squad Car," over station WHAS Sunday night at 10:15 p.m., according to Ros W. Harrison, public service director. The purpose of the program is to point up the problems of safety and law enforcement, and the role played by enforcement officials to make this a better community.

The program, which began September 12, is to run for thirteen weeks. One of the reasons for sponsoring the program, Mr. Harrison said, is that these organizations feel there is further need to educate people and to guide them into plans which are regulated and sponsored by physicians and hospitals themselves, plans which do not impose third party control.

New Booklet for M.D.s Available

"Estate Planning for Physicians" is the title of a booklet that has been made available to physicians on request by one of the Louisville banks. A card sent to the KSMA Headquarters Office, 620 South Third Street, requesting one of these booklets will be all you will have to do in order to receive one.

The booklet, for the most part, is made up of reprints of articles appearing in the Journal of the American Medical Association with certain additions to cover legislative developments and to provide further information on matters of particular interest to physicians. It is divided into four parts: the Business Side of the Physician's Life, the Young Physician's First Plan, Planning for the Middle Years—the Successful Physician, and Planning as Retirement Approaches.

The Cleveland Chapter of the Arthritis and Rheumatism Foundation and the regional members of the American Rheumatism Association are sponsoring a conference devoted to rheumatic diseases to be held November 10, at the Hotel Carter, Cleveland, Ohio. Inquiries should be addressed to William S. Clark, M.D., chairman, 2073 Abington Road, Cleveland 6, Ohio.

The Annual Meeting of the West Virginia Heart Association will be held in Huntingdon on Friday, November 5, at the Frederick Hotel, according to Walter C. Swann, M.D., president of the West Virginia Heart Association. For further details contact your KSMA Headquarters Office.

The Chicago Medical Society for the eighth consecutive year has organized postgraduate courses for the medical profession, according to Frank H. Fowler, M.D., president. A course in Basic Principles and Recent Developments in Internal Medicine is scheduled for November 8-12, and a course in General Surgery will be offered November 15-19, 1954.

The state medical associations of California and Arizona have received special recognition for their outstanding contributions to the American Medical Education Foundation. California presented a $100,000 gift recently and Arizona donated $7,230.

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News Items

Anthony J. J. Rourke, M.D., who formerly practiced at Ft. Thomas, has announced that he is now engaged in hospital consultation at New Rochelle, New York.

Ellis Duncan, M.D., recently opened an office in St. Matthews and will limit his practice to general surgery. Dr. Duncan was graduated from the University of Louisville School of Medicine in 1936 and interned at Louisville General Hospital. He took a residency in general surgery at New York Postgraduate Hospital, New York City, and additional training in cancer surgery at Ellis Fischel State Cancer Hospital, Columbia, Missouri. From 1942-1945, Dr. Duncan did surgical work overseas with the United States Army. For the past five years he was assistant chief of surgery at the Veterans Administration Hospital, Louisville.

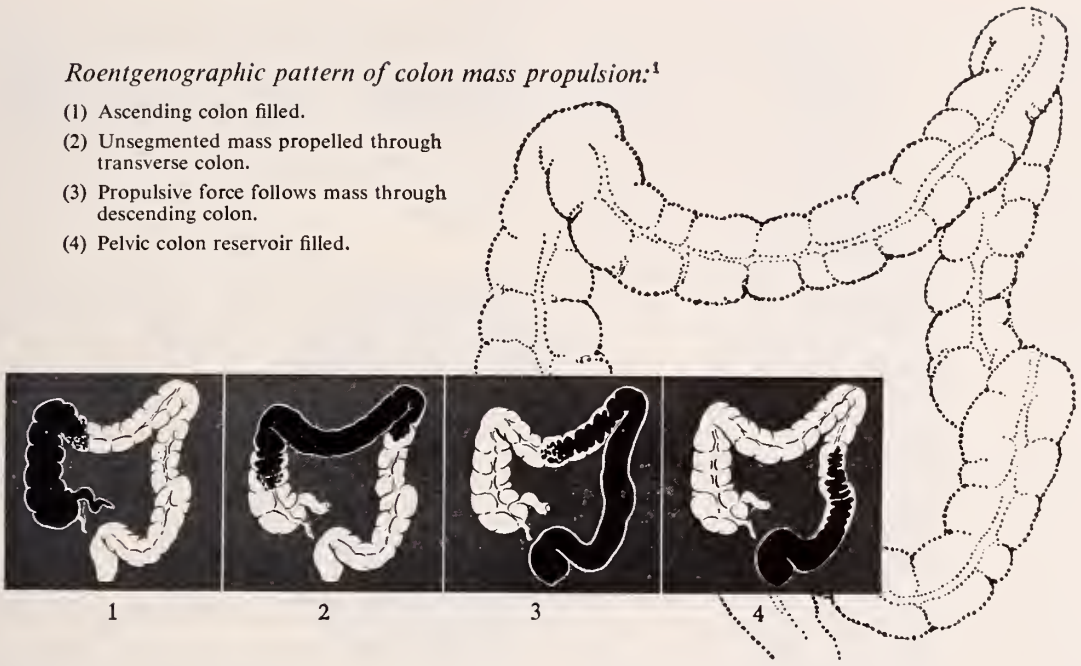
David H. Neustadt, M.D., recently opened an office in Louisville for the practice of internal medicine and rheumatology. Dr. Neustadt was graduated from the University of Louisville School of Medicine in 1950 and interned at Morrisania City Hospital, New York City. He took a two year residency in internal medicine at the Lenox Hill Hospital, New York City, and was granted a clinical fellowship in rheumatology by the National Arthritis and Metabolic Institute. During the past year Dr. Neustadt was a resident in gastroenterology at the Lenox Hill Hospital.

Harold William Baker, M.D., recently became associated with **Laman Gray, M.D.,** Louisville, for the specialty of gynecology. Dr. Baker received his medical degree from Johns Hopkins University School of Medicine, Baltimore, Maryland, in 1948 and interned at Vanderbilt University Hospital, Nashville, Tennessee, where he also took a sixteen months residency in obstetrics and gynecology. In addition, he took a two year residency in gynecology at Johns Hopkins University Hospital. Dr. Baker, who is a native Texan, served with a medical detachment of the United States Air Force from November, 1950, to July, 1952.

Sam Overstreet, M.D., Louisville, attended the Third International Congress of Internal Medicine held in Stockholm, Sweden, September 15-18, 1954. Representatives from 40 nations attended the Congress, sponsored by the International Society of Internal Medicine.

Roentgenographic pattern of colon mass propulsion:[1]

(1) Ascending colon filled.
(2) Unsegmented mass propelled through transverse colon.
(3) Propulsive force follows mass through descending colon.
(4) Pelvic colon reservoir filled.



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Correction of constipation logically, therefore, lies in the suitable adjustment of these factors. The characteristics of Metamucil permit the correction of most of these factors: it provides bulk; it demands adequate intake of fluids (one glass with Metamucil powder, one glass after each dose); it increases the physiologic demand to evacuate; and it does not establish a laxative "habit." Metamucil, in addition, is inert, and also nonirritating and nonallergenic.

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The average adult dose is one rounded teaspoonful of Metamucil powder in a glass of cool water, milk or fruit juice, followed by an additional glass of fluid if indicated.

Metamucil is the highly refined mucilloid of Plantago ovata (50%), a seed of the psyllium group, combined with dextrose (50%) as a dispersing agent. It is supplied in containers of 4, 8 and 16 ounces. Metamucil is accepted by the Council on Pharmacy and Chemistry of the American Medical Association. G. D. Searle & Co., Research in the Service of Medicine.

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1. Best, C. H., and Taylor, N. B.: The Physiological Basis of Medical Practice: A Text in Applied Physiology, ed. 5, Baltimore, The Williams & Wilkins Company, 1950, pp. 579-583.

2. Bargen, J. A.: A Method of Improving Function of the Bowel, Gastroenterology *13*:275 (Oct.) 1949.

Robert S. Tillett, M.D., has announced his association with John S. Llewellyn, M.D., Louisville, for the practice of internal medicine. Dr. Tillett was graduated from Western Reserve University, Cleveland, Ohio, in 1946, and interned at St. Luke's Hospital, Chicago. He took a two year residency in his specialty at St. Luke's Hosptial and a one year residency at Hine's Veterans Administration Hospital, Chicago. In addition, Dr. Tillett served from 1948 to 1950 in the United States Army and practiced for two years in Goldsboro, North Carolina. He is a native of Ohio.

Allan F. Zoeller, M.D., has announced his association with **K. Armand Fischer, M.D.,** and Kenton D. Leatherman, M.D., Louisville, for the practice of orthopedic surgery. Dr. Zoeller received his medical degree from the University of Louisville School of Medicine in 1948 and interned at Jackson Memorial Hospital, Miami, Florida. He took a residency in general surgery at Evangelical Deaconess Hospital, Milwaukee, Wisconsin. He received his training in orthopedic surgery at Kosair Crippled Children's Hospital, and General Hospital, Louisville.

Robert Hansen, M.D., deputy health director for Louisville and Jefferson county since 1952, in September moved to New York to assume his new duties as medical-programs consultant for the United States Public Health Service in ten northeastern states. He will advise local and state health departments on general medical programs.

Douglas L. Gillim, M.D., has announced his association with **Robert F. Monroe, M.D.,** Louisville, for the practice of obstetrics and gynecology. Dr. Gillim was graduated from the University of Michigan Medical School in 1950 and interned at General Hospital, Louisville. He took a three year residency in his specialty at University Hospital, Ohio State University, Columbus. In addition, he has spent three years in the United States Navy.

G. R. Tanner, M.D., 1947 graduate of the University of Louisville School of Medicine, is the new assistant pathologist at St. Elizabeth Hospital, Covington. He will also teach medical technology at Villa Madonna College there. Dr. Tanner practiced in Owenton from 1948 to 1950.

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WASHINGTON NEWS DIGEST

Washington, D.C.—When the 84th Congress convenes in January, the Eisenhower Administration will press for passage of at least two bills that failed to get through last session, reinsurance and a new program of medical care for military dependents. The former was decisively defeated in the House. The latter did not reach a vote in either chamber.

In a radio address summing up his Administration's legislative achievements, Mr. Eisenhower confirmed that he was prepared to renew the fight next session to have the federal government set up a system for reinsuring health insurance programs. He declared: "Health reinsurance we are going to put before Congress again because we must have a means open to every American family so that they can insure themselves cheaply against the possibility of catastrophe in the medical line."

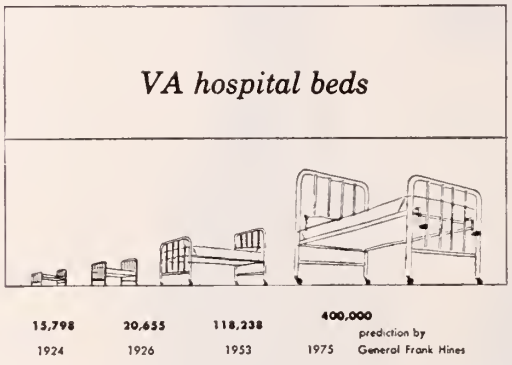
There have been no indications how far the Administration would go in amending the reinsurance bill to satisfy its critics. It is possible also that if all objectionable features were removed there would be little left of the bill.

At Senate and House hearings, reinsurance was roundly denounced by most witnesses, for a variety of reasons. AMA's position was that reinsurance wasn't needed because private funds are available for the limited amount of reinsurance that could be used, and that in addition the program projected the federal government too far in the direction of control on medical care.

Later in the session, Mr. Eisenhower himself and Mrs. Hobby made every effort to win over critics of reinsurance, and to force the bill through Congress. In the light of these efforts —including a nationwide radio appeal by Mrs. Hobby—the defeat of the bill in the House of Representatives was regarded as one of the most surprising suffered by the Administration on any domestic legislation.

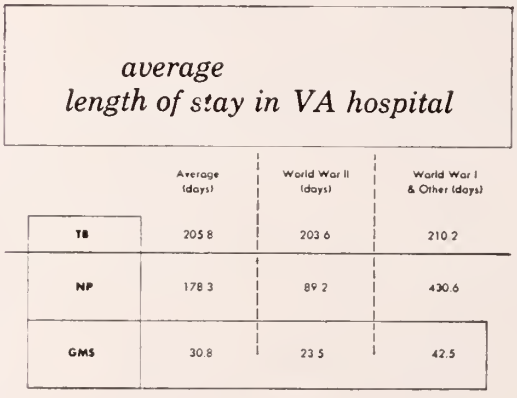
Currently Secretary Hobby and Chairman Charles Wolverton of the House Interstate and

In Viewing the VA Medical Program . . .



Former VA Administratar Frank Hines estimated that by 1975 under existing VA medical legislatian, appraximately 400,000 hospital beds will be needed. Yet medical authorities are canvinced the VA cannat attract sufficient medical personnel to staff more than 120,000 beds. The VA naw maintains three times the number af beds needed for treatment af service-cannected cases.

In Viewing the VA Medical Program . . .



	Average (days)	World War II (days)	World War I & Other (days)
TB	205.8	203.6	210.2
NP	178.3	89.2	430.6
GMS	30.8	23.5	42.5

The average length af stay in VA hospitals far Warld War I veterans is considerably greater than for Warld War II veterans, which now comprise 76% of the total veteran papulatian. The greatest pressure is yet ta be exerted an VA haspitals as World War II veterans graw older and require increased medical care far disabilities unrelated to military service.

Foreign Commerce Committee are attempting to bring together all parties interested in health legislation to see if a compromise can be worked out on reinsurance.

Although the dependent medical care bill wasn't passed, this fact was not in any way regarded as a defeat for Mr. Eisenhower. The bill was offered in the Senate in plenty of time for action, but the introduction of the House bill was held up until Defense Department could estimate the first year's cost, eventually set at $67 million. At any rate neither Senate nor House Armed Services Committee held hearings on the measure.

In another statement, Mr. Eisenhower made it clear that he expects the next Congress to do something about improving and making more uniform the system of medical care for servicemen's families. Congress, he said, "must eventually meet certain imperative needs of the members of the armed forces." He explained that servicemen now "lack adequate medical care for dependents. . . It is most important that these needs of the armed forces personnel serving their country often in remote corners of the world engage our serious consideration."

Although the American Medical Association has not had an opportunity to testify on the dependent care plan before Congressional committees, it has made its views known to the Defense Department. In general the AMA is not opposed to Defense Department proposals that a more uniform system be worked out, and that the federal government bear most of the cost. On one important point, however, the recommendations of the department and of the Association are in direct conflict: The department would have the military medical departments themselves furnish dependent medical care wherever they could, with service families going to private physicians and private hospitals only where the uniformed physicians couldn't handle them. The Association, on the other hand, proposes that dependents be cared for by the military medical departments only where civilian medical facilities are inadequate to furnish proper care.

Federal officials, meanwhile, are busy preparing to put into effect the new health bills passed by Congress. Basic state allotment percentages have been worked out for the new Hill-Burton program (for facilities other than complete hospitals) and for the expanded vocational rehabilitation program. The Internal Revenue Bureau is about to issue detailed instructions to taxpayers regarding changes in medical expense deductions and other benefits in the new tax law.

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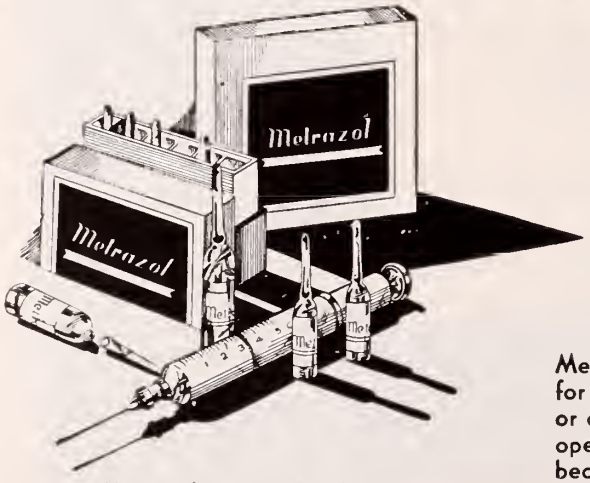
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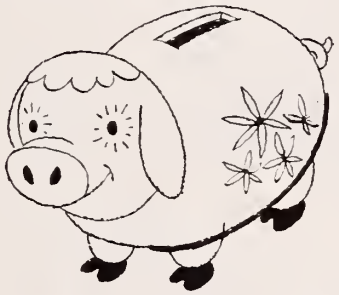
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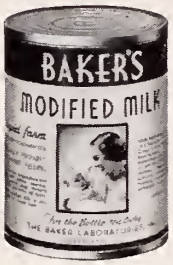
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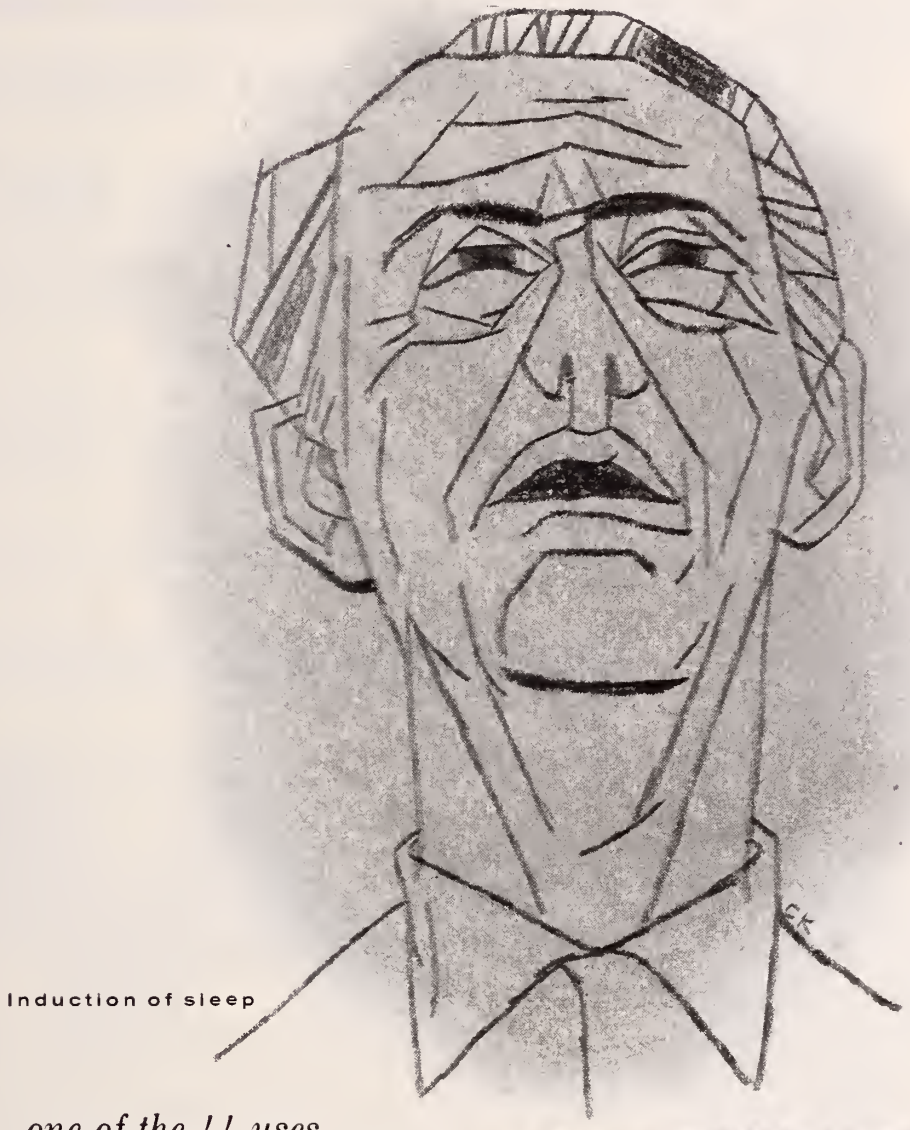
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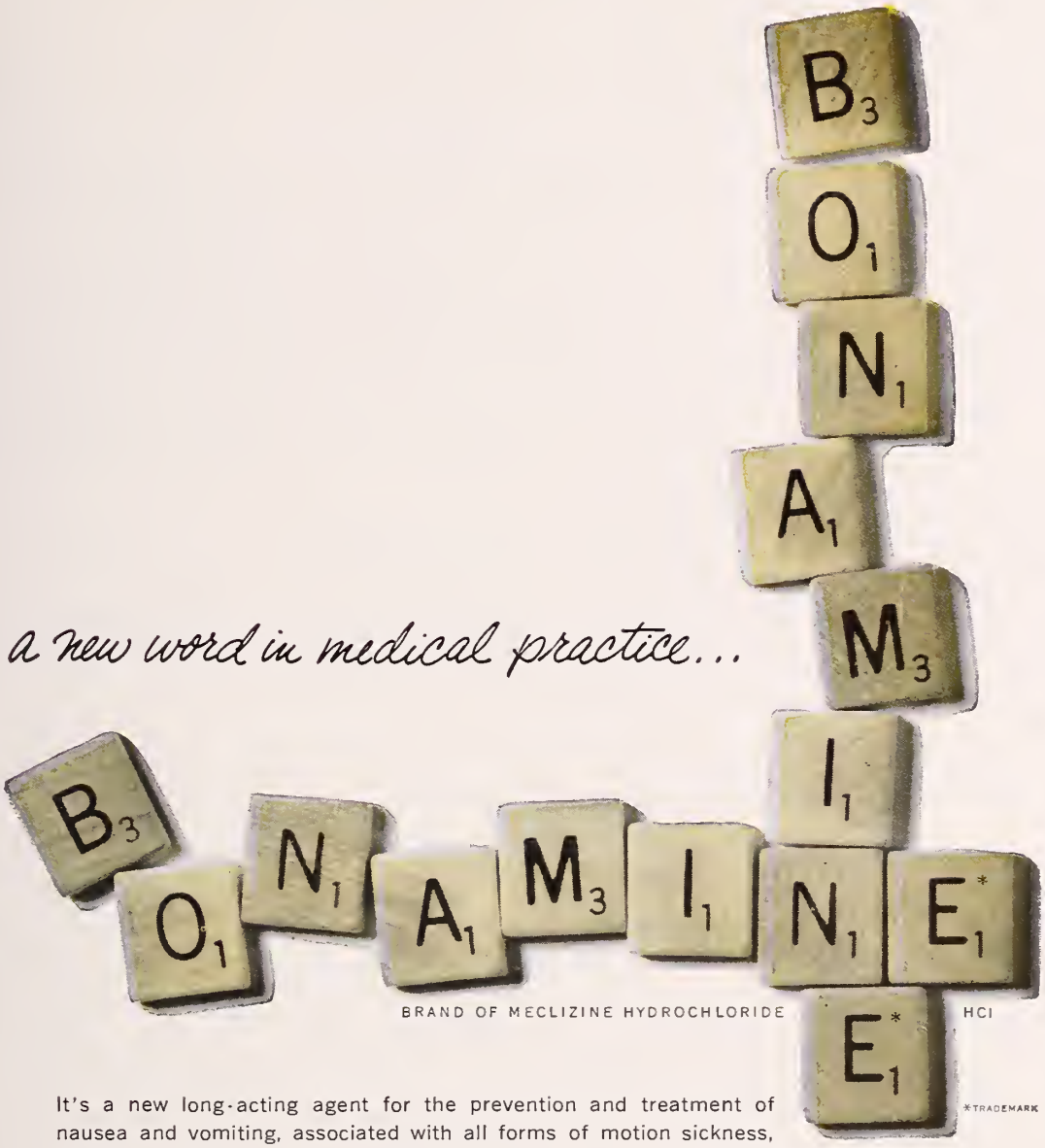
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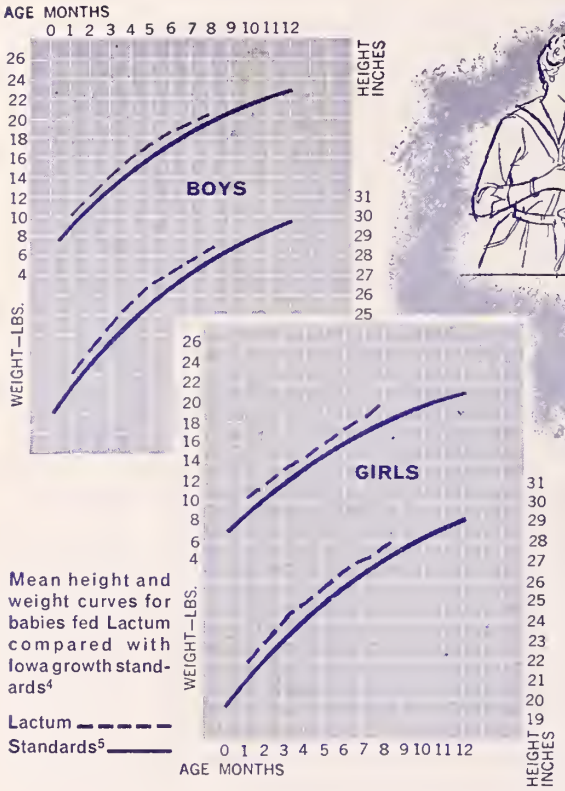


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(1) Jeans, P. C.: In A.M.A. Handbook of Nutrition, Ed. 2, Philadelphia, Blakiston, 1951, p. 275. (2) Albanese, A. A.: Pediat. 8: 455, 1951. (3) Holt, L. E., Jr., and McIntosh, R.: In Holt Pediatrics, Ed. 12, New York, Appleton-Century-Crofts, Inc., 1953, pp. 175-178. (4) Frost, I. H., and Jackson, R. L.: J. Pediat. 39: 585, 1951. (5) Jackson, R. L., and Kelly, H. G.: J. Pediat. 27: 215, 1945.

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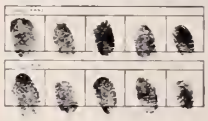


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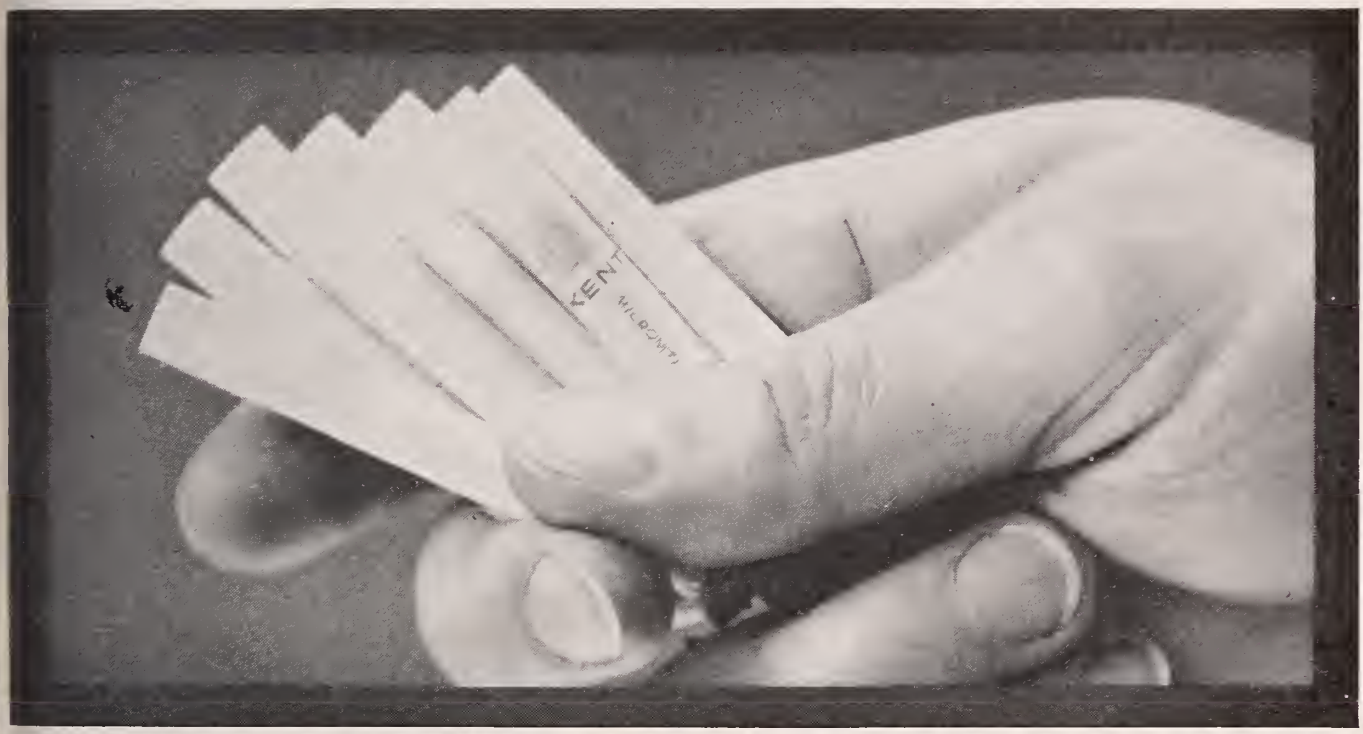
1. Werner, A.: Acta endocrinol. *13*:87, 1953.
2. Malleson, J.: Lancet *2*:158 (July 25) 1953.
3. Goldzieher, M. A., and Goldzieher, J. W.: Endocrine Treatment in General Practice, New York, Springer Publishing Company, Inc., 1953, p. 23.

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Meat...

and Its Contribution to Fat Needs

Fat, the most concentrated source of nutrient energy, constitutes a dietary essential in human nutrition.[1] It is needed in growth and replacement of tissues, for specific lipid secretions, and for providing physiologic energy.[1,2] Absorbed fatty acids may be incorporated into more complex lipids, deposited in adipose tissue, converted into other fatty acids, used in production of milk fat, transformed into glucose or glycogen, or oxidized to carbon dioxide and water with liberation of energy.[3]

Evidence indicates that long continued extremely low fat intake in adults is incompatible with good health.[4,a] In addition to protecting tissue protein against catabolism for energy needs (the protein-sparing action of fat), sufficient amounts of fat in the dietary promote storage of protein.[4,b] In a normal mixed diet, fat is about 95 per cent as efficient as carbohydrate for production of muscular work.[4,c]

Neither the optimal level of fat in the diet nor the optimal range for apportionment of fat and carbohydrate to meet calorie allowances is known.[1,2]

Contrary to general impressions, fat in the mixed diet is effectively digested.[4,d] In moderate amounts it does not appreciably influence the digestibility of other foods.[5] Fat enhances the satiety value of meals, and foods naturally containing fat and those prepared with fat add much to the flavor value of meals. High fat diets sometimes are useful in alleviating constipation.[6]

Meat, according to its kind and cut, provides variable amounts of fat which contribute importantly to the body's need for fat. The fat of meat is almost completely digested. Meat also supplies valuable amounts of high biologic quality protein, B vitamins, and essential minerals. Skeletal muscle meat contains less than 0.1 per cent of cholesterol.[7]

1. Goldsmith, G. A.: Application to Human Nutrition, in Bourne, G. H., and Kidder, G. W.: Biochemistry and Physiology of Nutrition, New York, Academic Press Inc., 1953, chap. 23, p. 505.
2. Recommended Dietary Allowances, Washington, D. C., National Academy of Sciences—National Research Council, Publication 302, 1953, p. 23.
3. Ekstein, H. C.: Fat in Nutrition, in Handbook of Nutrition, A Symposium, ed. 2, Philadelphia, The Blakiston Company, 1951, p. 23.
4. Sherman, H. C.: Chemistry of Food and Nutrition, ed. 8, New York, The Macmillan Company, 1952, (a) p. 30; (b) p. 198; (c) p. 115; (d) p. 103.
5. McLester, J. S., and Darby, W. J.: Nutrition and Diet in Health and Disease, ed. 6, Philadelphia, W. B. Saunders Company, 1952, pp. 130-135.
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7. Okey, R.: Cholesterol Content of Foods, J. Am. Dietet. A. *21*:341 (June) 1945.

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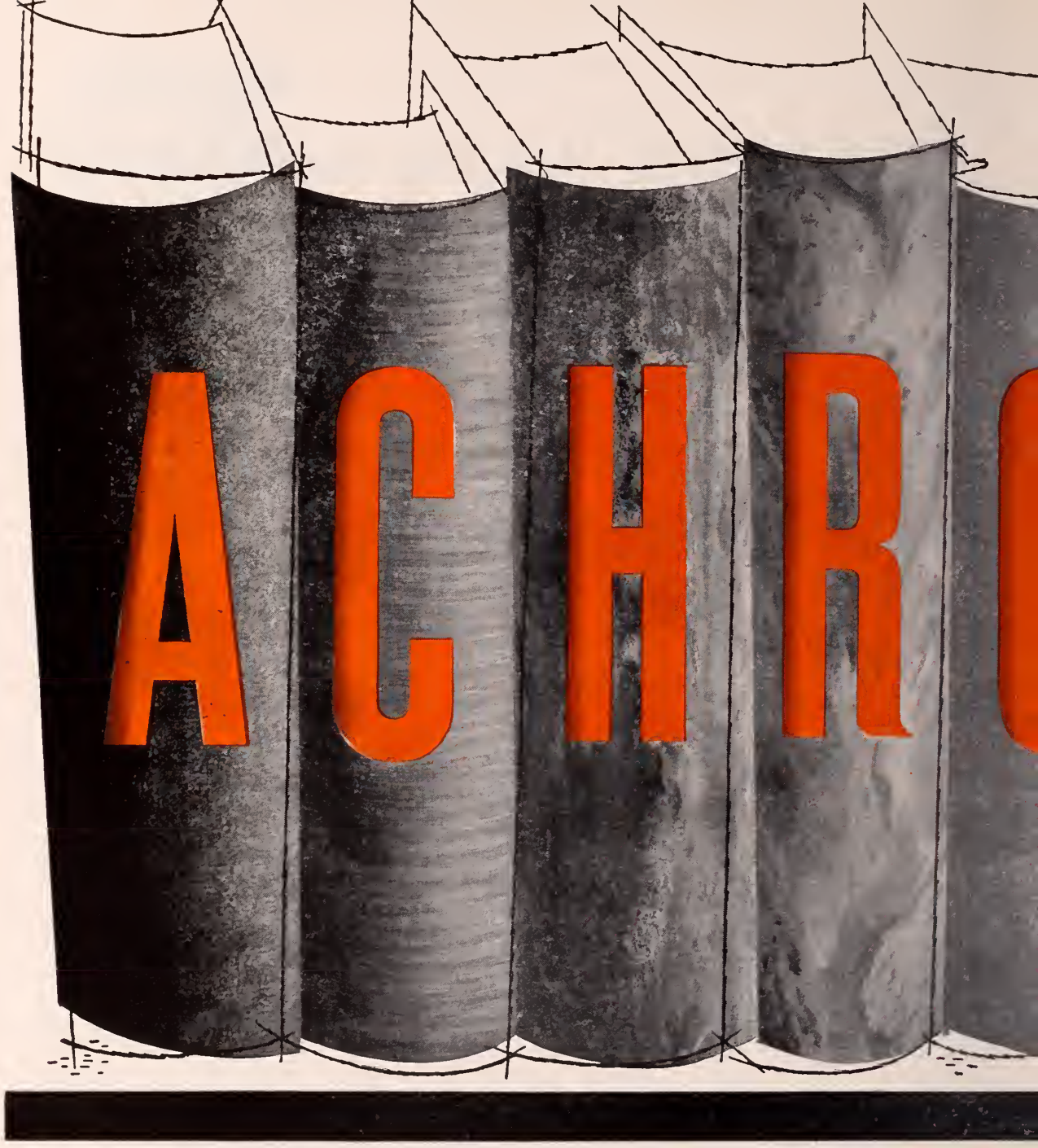
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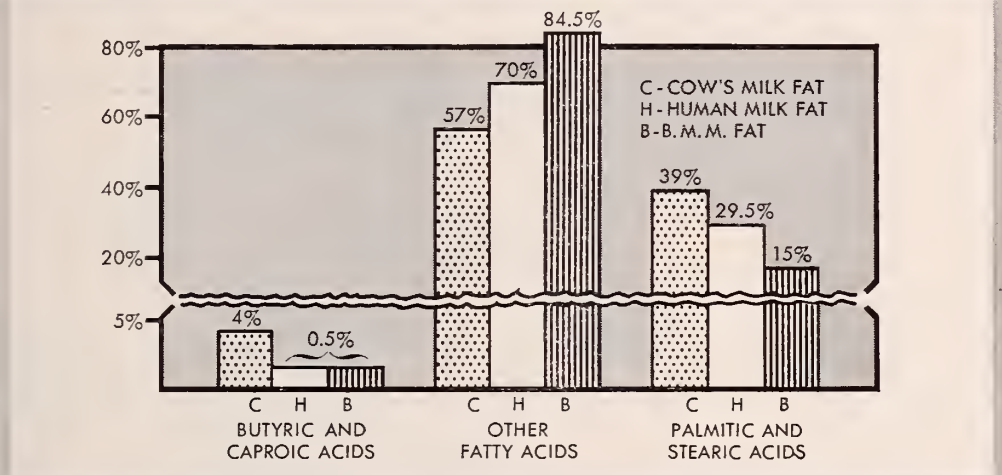
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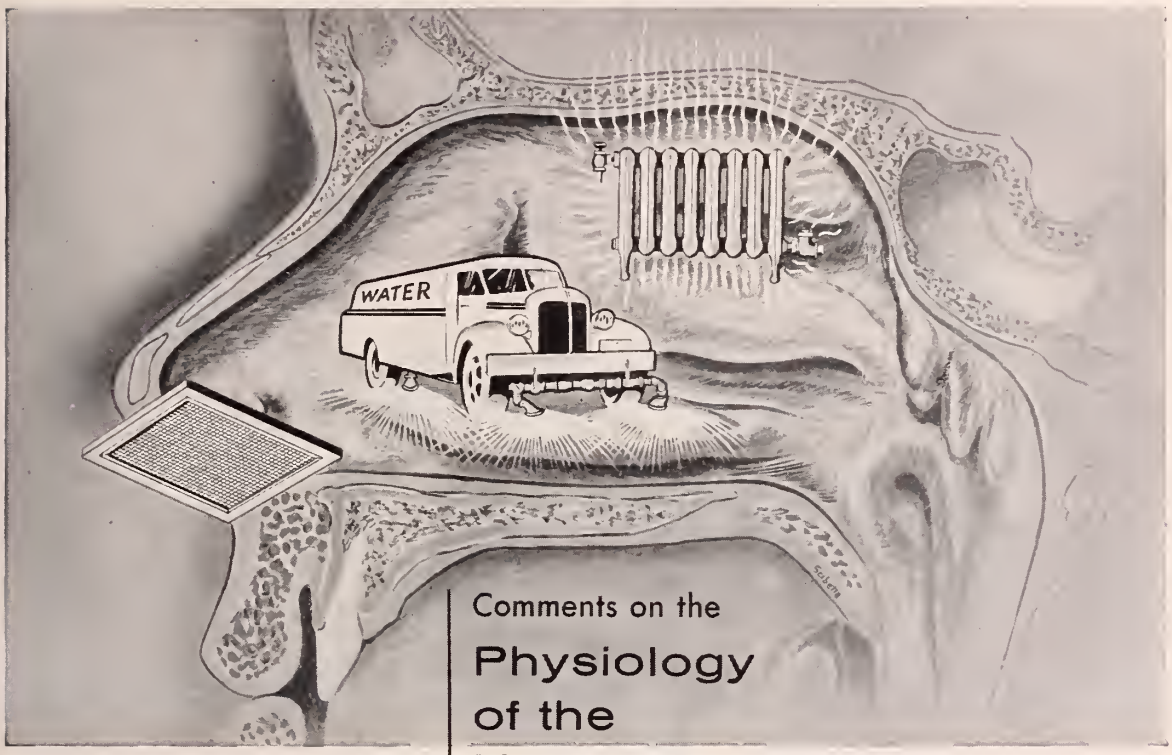
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Injuries Of The Hand*

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Cincinnati, Ohio

The hand, more than any other part of the body, is and has been subjected to innumerable types and degrees of trauma. In this era of chemotherapy physicians in general and surgeons in particular, are easily lured from the practice of sound surgical principles when called upon to care for these injuries. Frankly, I am fearful that there are those of us seeking "short cuts" who rely more on a syringe or capsule of a magic drug than those who rely on sound judgement.

General Principles

Many excellent papers have been written about the general principles in the treatment of wounds of violence of the hand and, while I will not reiterate the details these fundamental concepts are:

1. Careful first aid care to lessen further contamination of the wound.

2. Establish as correct a diagnosis as possible, which implies a complete history, thorough physical examination of the patient and the injury, and routine laboratory examination of blood and urine together with roentgenograms of the part when indicated.

3. These data should be analyzed carefully and intelligent plans formulated as a guide to correct surgical management.

4. Surgical toilet of the wound and surrounding area, usually, if not always, is best done in the operating room.

5. Superficial wounds may be managed under local anesthesia, but extensive and deep wounds usually require general anesthesia.

6. Operation in a bloodless field by using a pneumatic arm cuff.

7. Meticulous surgery to the wound, including complete removal of foreign material, blood clots and devitalized tissue only. Hemostasis must be secured and ligature material should be of the smallest size.

8. Definitive repair of all involved vulnerable structures when possible.

9. Closure of the wound by primary suture or by the use of grafts of skin if required.

10. Adequate surgical dressing with the hand in a functional position held by a splint and a compression dressing.

11. Chemotherapy should be used intelligently and antitetanus therapy should be given to every patient.

12. Immediate postoperative care must not be neglected.

In the general considerations of the problem of management of wounds of violence there are two factors, among many, which are most important in primary closure and ultimate healing of the wound. These are time interval between injury and treatment and the degree of devitalized tissue produced by the act of violence. Both of these factors have a definite relationship to the degree of bacterial contamination of the wound, infection of the wound and the behavior of tissue during their restorative phase. These are the factors which largely control the production of greater or lesser amounts of scar tissue which so frequently determines the final functional result of the hand.

Time Interval

In our clinic we have emphasized the importance of definitive surgical treatment as soon as possible. The optimum

*Read before the Kentucky General Practitioner's Meeting, Cincinnati, Ohio, April 22nd, 1954.

From the Department of Surgery and Hand Clinic, College of Medicine, University of Cincinnati and the Cincinnati General Hospital.

time interval to accomplish primary repair is during the first six hours. In selected instances this interval may be extended, but consolation is found in the dictum "the shorter the interval of time, the better wound healing."

The surgical care of the wound employs many of the basic principles. Aseptic technique is better controlled in the operating room rather than in the emergency department. Unless there are contraindications general anesthesia should be used for the extensive and deep wounds of the hand. The more superficial wounds may be treated under local anesthesia either by local infiltration or by regional or brachial plexus block. I am certain that infants and young children are handled best under general anesthesia. The drunk patient is not a candidate for general anesthesia. After the patient is asleep the pneumatic cuff is applied and elevated to 260 mm. of mercury pressure following proper venous drainage from the extremity. This technique insures operation in a bloodless field. The upper extremity is then properly cleansed, which includes shaving of the hair from the skin and removal of all dirt and grease from the skin and from under the nails. We have found that hexachlorophene detergent is an excellent field preparation. The extremity is then properly cleansed and draped, which includes the hand and forearm. Meticulous debridement can now be done. All foreign matter in the wound including dirt and clots of blood are removed. Contrary to the opinion of many the surgeon can see small vessels in the avascular wound and these may now be ligated with small silk. Of importance is the removal of all devitalized tissue, but it is important in principle that all viable tissue is spared.

There is no place in the body where living tissue is more important than the hand. Mason has stressed repeatedly the fact that there are no excess tissues for waste in the hand. At this point we advocate irrigation of the wound, using isotonic salt solution and being gentle in the method of its use. The amount of solution used depends upon the degree of dirt in the wound. This mechanical cleansing we believe is helpful in minimizing infection. At this point all involved vulnerable structures are repaired except when such repair is contraindicated and when secondary repair is definitely the procedure of choice. In all instances the finest of suture material should be used. Finally the wound is closed. This closure can usually be accomplished by primary suture without tension on the edges of the skin. Where there has been loss of skin and subcutaneous tissue associated with various defects of the epithelial structure, closure of the wound can be accomplished by the use of relatively thick split-thickness grafts of skin. Only in selected instances is there need to drain these wounds provided the surgeon has attended all of the details stressed in the proceeding paragraphs.

Debridement

Almost every surgeon believes that his technique for debridement is correct. Actually, there is no perfect method for it is impossible in all wounds to secure what may be considered perfection. Furthermore, when vital structures have been injured it is impossible to carry out any conceivable procedure such as total debridement would imply. In such cases partial debridement is used and when the fundamental principles are followed the results are usually very good.

The careful surgeon will attend to a proper dressing for the hand, which in the majority of instances can be described as consisting of a large dressing which gently compresses the tissues and is supported by a splint with the digits in a position of function. Antitetanus therapy should be given to every patient making sure that the patient is not sensitive to serum if tetanus antitoxin is being used. There is no question about the efficacy of tetanus toxoid when a patient has previously been immunized. In severe crushing and mangling injuries the daily use of antitetanus therapy over a period of several days may be indicated. The intelligent use of chemotherapeutic agents is important and we believe that penicillin and/or Terramycin are two agents which should be used. In some cases there may be no indication for the use of them while in other cases their prolonged use is imperative. If wound healing is complicated by a suppurative process certainly sensitivity studies of the bacteria to the various chemical agents should be done.

The purpose of this presentation is to discuss the exact treatment of various injuries of the hand in terms of present knowledge. Every type of injury conceivable cannot be discussed and I plan to group many injuries to a geographical location.

Finger Tip Injuries

Finger tip injuries are frequent in civilian and industrial practice. These injur-

ies consist of subungual hematoma, avulsion of the nail from its bed, contusion of the distal interphalangeal joint (baseball finger), compound fracture of the distal phalanx and complete amputation of the finger tip. All of these injuries may be considered minor to the physician and yet loom as a major catastrophe in the patient's mind; this is particularly true if the injury occurs to one or more of the important digits which is useful to the patient's earning capacity.

Of all of the above mentioned finger tip injuries perhaps the most common one is partial amputation of the finger tip. Actually the tip of the finger may be sliced off by means of carving knives, sharp tools and various types of mechanical gadgets. In many instances the fat pad is spared, and only the thick epithelial covering has been removed from the anterior space. In such an injury of the finger tip the wound should be properly treated as outlined and primary closure should be done. I believe that the equivalent of a large pinch graft or thick split-thickness graft easily closes the wound, prevents infection and above everything else results in a healing process with minimal scarring and tenderness in this region. The greatest pitfall is to treat this wound as an open wound.

When the traumatic amputation involves the fat of the anterior space and even a portion of the distal phalanx, immediate pedicle grafts from the palm of the hand may be used to bridge the defect. In some instances there may be sufficient viable skin of the finger tip to allow primary closure. In any case the wound should be closed.

Injuries from Rollers and Wringers

The hand and forearm are frequently caught in rollers such as seen in the printing press industry or in laundry wringers by both mother and child. These injuries vary in their degree of damage. They may extend from involvement of only the digits or the palm and dorsum of the hand, although in a few cases the entire upper extremity has been drawn through the rolling mechanism being only stopped by the shoulder girdle and thoracic cage.

In many cases there is extravasation of blood because of the pressure and subsequently hematoma formation is seen. Unless there is marked angulation of the extremity by the patient or by his would-be rescuer, fracture of the osseous system is almost never observed. When damage is limited to extravasation of whole blood one may see fibrosis of the tissue. This is particularly true in the hand where the intrinsic muscle of the thumb and digits become atrophic due to extravasated blood.

In other instances there may be avulsive skin flaps of the reverse type which require considerable judgement to obtain a satisfactory result. In some cases the skin defect can be bridged by a thick split-thickness graft. In any event the wound should be closed.

In the more serious wringer injuries the brachial plexus may be involved and a temporary paralysis of the major nerves of the upper extremity may be noted.

Injuries to Tendons of the Hand

One of the most disabling injuries for the patient and one of the most disheartening injuries for the surgeon is tendon injury. The degree of disability and the amount of time consumed in the management of such patients are only two factors to be considered in this problem. The surgeon must take a very definite stand on the approach to the proper management of tendon injury and I believe the time has now come when specific surgical treatment must be outlined in tendon injury.

In short I believe all divided extensor tendons can be repaired primarily and that the ultimate end results are good. Also, I believe that all divided flexor tendons proximal to the flexor tendon sheath can be repaired primarily. Conversely, when the flexor tendons have been divided within the tendon sheath the problem is entirely different. As a matter of fact, analysis of cases properly followed, will probably reveal the inadequacy of primary repair. This location by discussion has been called "no man's land" for a very good reason. Almost invariably there is blood within the tendon sheath following injury and although the surgeon may only repair the profundus tendon, there is sufficient irritation to freeze the gliding mechanism, giving a final poor functional result. So much is this true that I am at the point of dictating a policy of secondary repair only. Under these circumstances primary tenorrhaphy would never be accomplished when division has occurred within the tendon sheath. Secondary repair would be accomplished by means of tendon graft in order to assure a gliding mechanism. This graft can be obtained from the extensor to the fourth and fifth toes of the foot and is transplanted to the hand within the sheath, being sutured distally to the distal

phalanx and proximally to the end of the flexor digitorum profundus tendon. In unusual cases the sublimis tendon would be used. It seems likely that analytical comparative study between primary repair and secondary repair by graft will decide this important issue. Under any circumstance the ultimate results to date have not been gratifying in the hands of the majority of surgeons.

In passing I should like to stress the point that a good functional result must be interpreted in terms of flexion of the finger so that the finger tip is within 1 cm. range of the palm of the hand. Anything less than this range implies a poor or bad result.

Injuries to Nerves of the Hand

Injuries to nerves of the hand are serious and disabling. In many wounds of violence there is frequent mixed injury to tendon and nerve. The physician must recognize this possibility in order to rehabilitate the hand.

It must be apparent from anatomical knowledge that the ulnar and median nerves are the only two major nerves in the hand. Both of these nerves may be damaged at the level of transverse volar ligament or any point distalward. It is imperative, therefore, that the surgeon make a careful examination of the part and in so doing a thorough neurological examination must be done. Anyone familiar with the exact tests of motor and sensory function of the digits should make an accurate diagnosis of nerve division. The exception to this rule is in the unconscious patient or the child who cannot cooperate. Basically, an accurate preoperative diagnosis is important. Nerve repair can only be accomplished when nerve damage is sought.

I am sure that all divided nerves can be repaired and the small digital nerve on the lateral side of each finger is no exception to this rule. The same surgical principles which obtain for nerve repair also obtain for repair of the wound in general. Unless the nerve ends are severely contused or unless there has been loss of nerve trunk substances, adequate neurorrhapy can be done.

In the smaller nerve trunks three or four sutures of 6-0 silk through the perineurium will adequately repair this structure. When major nerve trunks are divided sutures of 5-0 silk at the four major points of the compass are used. Between these sutures interrupted sutures of 6-0 silk can be placed to approximate the perineurium. In all instances it is important to have all of the nerve bundles contained within the site of repair, which apparently lessen the possibility of neuroma formation.

I believe that immediate neurorrhaphy in civilian practice is very superior to delayed and/or secondary neurorrhaphy. When surgeons follow the fundamental principles previously outlined and when nerve ends are approximated with the greatest possible care, excellent results can be obtained.

Finally, it behooves the surgeon and physician to properly instruct and intelligently advise the patient in whom there has been damage to a nerve. He must be made to realize the reason for anesthesia of a part as well as motor disturbance of a part in conjunction with the time required for nerve regeneration to occur. This is imperative since the patient can protect himself during the several months which are required for axones to regenerate.

Fractures in the Hand

Simple and compound fractures in the hand are not uncommon. This discussion is not in any way to be construed with an orthopedic symposium, however, infrequently simple fractures including small chipped fractures occur in the phalanges and are overlooked simply for the lack of roentgenographic evidence. This point is stressed because most injuries of the hand should have x-ray examination. Simple fractures of metacarpal bones and phalanges are not difficult to manage since in the majority of cases there is no derangement of bone segment. In compound fractures and comminuted fractures there may be rotation of fragments and deformities may occur. It is my firm opinion that compound fractures of the bones of the hand require the same surgical approach as do wounds of violence in general. There are many ways to splint compound fractures, all of which have their advantages and disadvantages. It is important to consider the hand as a flexible mobile unit and this fact should govern the type of splint used and the duration of its use in order to effect a useful hand. Splinting bones of the hand over a period of many months can lead only to a poorly functioning hand. Furthermore, one must consider the possibility of injury to other vital structures when dealing with compound fractures of either the metacarpal bones or phalanges of the digits. Obviously this includes nerve and tendon division, either partial or complete. When such fractures are associated with division of other vital structures, one should hope to obtain the best result by intelligently approaching the

individual case. In these cases surgical intelligence, surgical approach, surgical finesse and many hours of hard work will help tremendously in reconstructing a badly damaged hand.

Summary

In conclusion, fundamental principles have been outlined which should guide the physician and surgeon in dealing with injuries of the hand. An attempt has been made to present various types of injuries and sound surgical approach to their definitive treatment has been discussed. It is hoped that the application of these broad concepts will obtain better results and eliminate to some degree the poorly functioning and crippled hands.

Some Often-Neglected Aspects of Urinary Calculus Disease

L. DOUGLAS ATHERTON, M.D.

LYTLE ATHERTON, M.D., F.A.C.S.

Louisville

After the severe colic of ureteral calculus has subsided with passage of the stone, or after an acute calculus pyelonephritis has been cured by nephrectomy, too often both patient and doctor lose interest in the matter. For most of these patients the problem remains solved because there is no further stone formation or no recurrence of severe symptoms. However, occasionally, recurrent stones become quite a nuisance and with or without infection lead to steadily progressive renal decompensation. Because the late stages of this latter group present a relatively hopeless situation, it is of great importance to apply what knowledge we have of stone formation and prevention in every case of urinary calculus disease.

We do not understand all the facets of this rocky problem, and there appears to be some confusion over the relative importance of the evidence we do have available. Since most cases of urinary calculus disease probably can be adequately handled by the family doctor, it is in the public interest to pass along what information we can so that he can broaden his scope of treatment, in some cases abort serious kidney damage, and better enjoy the practice of his art.

First we need to consider some very fundamental concepts. Urine is a supersaturated solution of crystalloids. This means that if an attempt were made to dissolve the quantity of crystalloids found in an ordinary urine sample in an equal volume of water, only a fraction of these materials would go into solution.

The reason for this extremely useful property of urine seems to lie in its high content of colloid. Colloid solutions are capable of supersaturation apparently by causing some ions to adhere to their surfaces, thus preventing precipitation. The knowledge of this colloid business is the basis of some interesting work now being done in an attempt to correlate it with stone formation. Perhaps the quantity of crystalloid output as well as the character and amount of urinary colloid is related to changes in the interstitial ground substance of the body in general, as suggested by some very recent research. Exactly which is the cart and which is the horse in the evaluation of these factors is not at all clear at the present time.

In normal urine under average conditions the crystalloids found in the usual urinary stones remain in solution. If the concentration of crystalloids for some abnormal reason tends to exceed the saturation mark even for this colloid solution, then precipitation is likely to occur. As one might expect, this appears to happen in a region where the velocity of flow is least, in a renal calyx or collecting tubule of the kidney.

Alterations in the collecting tubular epithelium or lining epithelium elsewhere in the urinary tract appear to favor stone formation at these sites, apparently by altering surface tension at these places. This may be one reason why urinary tract infection or trauma predisposes to stone formation.

Another important factor in the formation of some stones is the pH of the urine. This will be elaborated below.

In short, then, the basic factors involved in stone formation appear to be: (1) the concentration of crystalloids, (2) factors influencing the solubility of crystalloids, including urinary colloid and pH, (3) factors altering the lining epithelium of the urinary tract favoring localized deposition

of precipitate, and (4) the velocity of flow, or current.

In applying these four modalities of stone formation to their best advantage, it is necessary to know the type of stone with which one is dealing. This can usually be told by the appearance of the x-ray or by the gross configuration of the stone itself. For example, calcium-containing stones are radiopaque. Calcium phosphate stones are usually smooth and may be laminated. Calcium oxalate stones are often sharply spiculate, cast a dense shadow, and are quite hard. Uric acid stones are usually not visible by x-ray. Cystine stones may vary in density between these two extremes, depending upon the amount of calcium incorporated in the stones. Many times it is of great importance to analyze these stones in order to be certain of their constituents. This can easily be done in one's own office if the number of stones examined warrants expenditure for the proper chemicals and simple equipment. In brief, the principle stone types are calcium oxalate, calcium phosphate, uric acid, and cystine. Xanthine stones are quite rare and probably fall into the practical group of uric acid stones.

Relative to the matter of stone analysis, it is of interest to note that prior to 1852 Dr. Robert Peter of Lexington, Kentucky, had analyzed several hundred bladder calculi in a manner perhaps more thorough than we usually employ today. This information together with elaboration of current surgical technics and other incidentals was summarized by Dr. Samuel D. Gross in the Transactions of the Kentucky State Medical Society published in 1853. At that time the opinion prevailed that calculus disease was more frequent in "limestone than in freestone regions." The idea of a dietary basis for calcium stones, then, was clearly established over a hundred years ago.

Calcium Stones

About 95% of all urinary tract stones contain gross quantities of calcium.

In investigating this type of urinary tract calculus disease one always thinks of hypercalciuria. There are a number of recognized causes of hypercalciuria including hyperparathyroidism, hyperthyroidism, osteoporosis when the disease is progressing, high calcium intake, multiple myeloma, some kinds of malignancy metastatic to bone, sarcoidosis, renal tubular acidosis, vitamin D poisoning, and a few others.

In some of the above, urinary tract stones are rarely a complication. In renal tubular acidosis, for example, the usually dilute character of the urine prevents concentration of crystalloids beyond limits of solubility, even though the 24 hour urinary calcium may exceed the upper limit of normal. The tubular disease involving processes responsible for conservation of basic cations will result in a loss of base in excess of need, a relative acidosis, mobilization of calcium from bone, and hypercalciuria. If concentration permits, the sequence proceeds with stone formation in collecting tubules and, theoretically, more tubular damage from this source. A vicious circle appears which is modified only when hyposthenuria more favorably influences calcium solubility. By this time mechanical damage to the tubular epitheluim may add its influence to the crystalloid precipitation.

As suggested by Albright and others, administration of alkali as sodium citrate or sodium bicarbonate relieves the relative acidosis, restores calcium to bone, and obviates the necessity for the body to utilize calcium as a base to neutralize its acid for excretion. This reduces the calciuria somewhat and lessens probability and speed of further renal calcification. Admittedly, it is often difficult to tell which came first, hypercalciuria or tubular disease. But with evidence favoring abnormal loss of base, relative acidosis, and renal stones (usually nephrocalcinosis), it would seem very worthwhile to press hard on alkali therapy.

Although the urinary excretion may be quite high in hyperthyroidism, stones are uncommon for some mysterious reason. Possibly there is also an alteration in urinary colloid, part of the disease, which increases the solubility potential of calcium. The increased calcium output appears to be the result of osteoporosis which often accompanies this affliction.

The reason for hypercalciuria in sarcoidosis is apparently related to decalcification often seen in the bones of these patients. There is often an elevated serum calcium, but no accompanying hypophosphatemia which is a factor to differentiate it from hyperparathyroid disease. There is said to be a moderate risk of urinary calculus formation[1].

In general, in the other diseases above, the hypercalciuria results either from excessive mobilization of calcium from diseased bone or from excessive absorption of calcium from the intestines. The dietary

factor, which is the easiest corrected, must not be overlooked.

It is, therefore, important to rule out non-dietary hypercalciuria. Accordingly, we instruct our patients in a relatively low calcium diet (for practical purposes, excluding milk and milk products from the diet), and after a few days the urine is tested for gross calcium by means of the Sulkowitch reagent. This can be obtained from the average apothecary shop, and its formula is as follows:

oxalic acid .....2.5 gm.
ammonium oxalate .....2.5 gm.
glacial acetic acid .....5.0 cc.
distilled water .....q.s.ad. 150 cc.

One simply fills an ordinary test tube about half full with urine and adds about 2 cc. of the reagent As the calcium oxalate precipitates out the solution becomes varyingly opalescent, and one learns to read this as three or four rough grades of intensity. We usually note the specific gravity of the urine on the same specimen, and attribute greater significance to a more positive Sulkowitch occurring in relatively dilute urine. This test by no means is a proof of excessive calcium excretion. It simply furnishes a clue in narrowing down this large group of patients and suggests some which may be manifesting hypercalciuria.

When the Sulkowitch test is moderately strong on several urine specimens, we then feel the point is worth further exploration. The patient is put on a strict (and less pleasant) low calcium diet containing less than 0.2 gram of calcium per day[2], and after four or five days a 24 hour urine specimen is collected for a quantitative determination. If this specimen shows greater than 200 mg. calcium in the total 24 hour output, it is indicative of hypercalciuria and one of the above causes for the condition is sought for. By history and physical examination, we have probably already excluded some of these causes.

Having ascertained excessive calcium excretion, we then commit the patient to further expense and study by obtaining blood calcium, phosphorus, and alkaline phosphatase. These will incriminate or rule out most cases of hyperparathyroidism. One must remember that in this disease the only clinical manifestation in over 75% will be urinary tract calculi, either calcium phosphate or calcium oxalate. When the blood chemistries are borderline, one should obtain the total protein in order to estimate the amount of ionized calcium as opposed to calcium bound to protein, and the significance sought in a table presented some years ago by McLean and Hastings[3]. These delicate tests need confirmation by repetition, and once into it the cost of this laboratory diagnosis mounts up. It is out of consideration for the patient's pocketbook that we stage the above steps.

When hyperparathyroidism is incriminated, it is most important that the disease be corrected by surgical removal of one or more parathyroid adenomas or by reduction in the amount of hyperplastic tissue. This is a job for a meticulous surgeon experienced in this type of problem, and is probably best not undertaken by operators who have not been initiated.

In arriving at the diagnosis of hyperparathyroidism, obviously in most of these cases the accuracy depends on the skill of the laboratory technician. The calcium determinations are subject to easy error, and one must have proof that the laboratory is quite reliable in this regard. Until recently this has been something of an obstacle to overcome in arriving at this diagnosis in Louisville.

A small group of patients will manifest hypercalciuria in spite of normal blood chemistries and in the absence of any other detectable abnormality. It is conceivable that in some types of renal tubular disease there can be impaired reabsorption of calcium without very noticeable damage to the elements responsible for urinary concentration and absorption of other salts. This highly selective pathology, involving a preponderance of tubules in much the same way, would seem rather improbable. For want of a better name these patients have been classified in a group labelled idiopathic hypercalcuria[4].

Having corrected or ruled out hypercalciuria, what other beneficial measures can be undertaken? If the stones are calcium phosphate, one might attempt to reduce the amount of excreted phosphorus or try to influence favorably the solubility of phosphates by insuring an acid urine. Basaljel or amphojel have the property of binding phosphorus in the intestine and decreasing its absorption. Practically speaking, these drugs present a formidable undertaking to the patient because of their constipating tendency and because of the large amount necessary to achieve hypophosphaturia. Use of an acid ash diet or of acidifying drugs is quite worthwhile. It is best to have the patient assure aciduria by instructing him in the use of nitrazine

paper and a urinary pH chart. By inducing a slight relative acidosis there is possibly some risk of mobilizing more calcium from bone and increasing calcium content of the urine. However, in the case of calcium phosphate stones and sterile urine, the risk would appear justified.

Calcium oxalate stones, when hypercalciuria has been excluded, are still an enigma. A large proportion of these stones have been determined to have a small nucleus of calcium phosphate, and measures for control of phosphate are therefor in order. Oxalate stones are probably the commonest stones formed in sterile urine, and the pure variety is almost equally insoluble in acid or in alkaline urine. It is not uncommon to find a calcium oxalate stone-former with a persistently low Sulkowitch test. He often denies an excessive intake of calcium containing foods, and in fact, may evince a pronounced distaste for milk or cheese.

Oxalate metabolism is not well understood. Oxalates appear to have an endogenous as well as exogenous origin. If, however, high oxalate-containing foods have been prominent in the diet of these patients, it would seem advisable to eliminate them.

Stilbestrol is said to increase the solubility of calcium in urine, apparently by increasing the excretion of citric acid which has a beneficial effect on the solubility of this cation. This form of treatment, if not distasteful for other reasons to the patient, is applicable as long as the urine remains sterile. In infected urine some organisms, including the common B. coli, destroy citric acid and offset this benevolence[5]. Aside from this, estrogens will increase bone production and probably decrease urinary calcium output.

One is often tempted to ascribe calcium stones forming in sterile urine to a period of relative dehydration in the face of an average intake of calcium. In hot environments, body fluid is diverted to a cooling mechanism and the urine becomes and remains concentrated. The effect may be to double the concentration of crystalloids available for calculus formation. Two or three months appears to be an adequate time interval for the formation of stones of this character, and, of course, hot summertime suggests its significance.

Another transient but possibly damaging hypercalciuria occurs after suddenly induced periods of recumbency in young, previously healthy patients. This type of thing has been mentioned many times and is sometimes seen following disabling fractures or severe poliomyelitis in children and young adults. In cases of this type where the immobilization releases large quantities of calcium from a skeleton which no longer requires it, it is important to curtail dietary calcium until the skeletal calcium reaches equilibrium. Reduction in calcium intake plus a high water consumption with consequent urinary dilution is the best measure to prevent urinary calculi in these cases. This is applicable, of course, to paraplegics and to other permanent and quickly induced disabilities.

Uric Acid Stones

Uric acid stones pose a fascinating and challenging problem which should provoke careful clinical research. One promptly thinks of gout when uric acid is mentioned, but there is very little to indicate that these two diseases are more than superficially related. The incidence of uric acid stones in gouty subjects hardly exceeds 1-3%. In urinary calculus disease in general the incidence of uric acid stone-formers does not appear to exceed 5%[6]. While gout in recent years has been subjected to intense scrutiny by means of radio-isotopes and exhaustive chemical studies, the uric acid stone-formers have not as yet received so much attention.

The one distinguishing characteristic about these people is the fact that the urine remains consistently and abnormally acid. We have not seen a single such patient whose urinary pH exceeded 5.5 in the absence of infection and without appropriate medication. It would seem that this fact accounts for the precipitation of uric acid into stones rather than a significantly increased urinary concentration of uric acid. In the absence of an acidosis, which seems clinically missing in these people, the fault would appear to lie within the acid-making machinery of the kidney. It is theorized that carbonic anhydrase is produced excessively and thus maintains the abnormally acid urine. The reason for this aberration is not at all clear.

The unusual urinary pH can often be of significant diagnostic help, particularly in those patients who have presented unmistakable signs of ureteral colic, who have not produced a stone, and in whom there is no distinct calculus by x-ray. One gains valuable information by having these patients keep a careful urinary pH chart. We have done this by supplying the patient with sufficient nitrazine paper, instructing him to check the pH of his urine

with every voiding, noting the pH of his urine and the time of voiding. In these patients the pH will not exceed 5.5, whereas in normal people or in victims of other types of urinary calculus the pH almost invariably rises to 6.5 or more on the alkaline side at some time during the day.

In treating these patients from a preventive standpoint, one thinks of two things: (1) decreasing the urinary uric acid by excluding dietary purines, and (2) increasing the urinary pH. The former is often not very practical because most of these patients have no history of excessive purine intake and, in fact, one has to scratch deeply in order to find a single dietary item to eliminate.

The second thought is quite practical in view of the fact that uric acid has a fairly wide range of solubility which increases markedly as the pH increases. It is not possible to foretell how much alkali is needed in order to insure an alkaline urine. The degree of the aciduria apparently varies from patient to patient. One usually prescribes from 3 to 24 grams of sodium citrate or soda bicarbonate per day in order to insure the proper change. This is best determined, again, by having the patient regulate his own dosage according to the dictates of the nitrazine paper urinary pH chart.

Since the abnormal aciduria has no known inclination for spontaneous remission, one is faced with the prospect of permanent medication of this type. It may be that intermittent urinary alkalinization will prevent calculus formation. We have pursued the policy thus far of maintaining these patients on an alkalinizing agent for from one to two weeks per month. The medication is not expensive and not particularly distasteful. If for some reason it is undesirable to furnish the patient with an excessive load of sodium, then a mixture of sodium and potassium citrate can be used to accomplish the same result. The substitution of a carbonic anhydrase inhibitor, which has recently been elaborated, may prove another practical method of handling this problem.

A survey of uric acid metabolism in these patients would be very much in order. By analogy, we could also profit by a study of the effect of uricosuric drugs used in various diseases, of the urinary situation in diseases characterized by excessive nucleoprotein destruction (as leukemia, hemolytic anemias, polycythemia), and by examining the urinary aspects of diseases exhibiting a chronic acidosis of pre-renal etiology, (as chronic diarrhea states, iliostomy, etc.). For example, we have recently observed predominently uric acid stones with calcium phosphate crust appearing in the infected urine of an incapacitated rheumatoid arthritic who had been on 100 mg. cortisone daily for a number of months. A few cases of uric acid stone-formers have been observed in patients with iliostomy for ulcerative colitis[6].

Cystine Stones

Cystine stone-formers are quite rare and are also rather anomalous. This disease appears to be the result of a metabolic defect involving the amino acid cysteine. The sulfur containing and perverted product cystine is excreted in abnormal quantity in the urine and has the property of being quite insoluble in acid urine. Since urine is normally acid most of the time, this results in calculus formation. The disease is a familial trait and often found in many members of the same family. These unfortunate people are identified by finding the typical hexagonal crystal of cystine in the urine.

Various methods have been tried in an attempt to eliminate cysteine by the substitution of other amino acids, but without very startling success. The main preventive measure is, again, the maintenance of a relatively alkaline urine in which cystine is considerably more soluble.

Mixed Stones

Many stones on chemical analysis reveal several different components. If possible, it is important to define what the basic and initial stone composition was. Here, stone analysis shows particular use.

One may find, for example, in a stone removed from an infected kidney that the innermost core consists almost entirely of uric acid. One would suppose then, that the underlying disorder is the uric acid malady with uric acid stone formation, secondary infection with urea splitting organisms, alkalinization of the urine secondary to infection, and precipitation of calcium phosphate upon the uric acid stone. Similarly, one might find a core of calcium oxalate with concentric rings of calcium phosphate which may indicate, again, superimposed infection with alkalinization and phosphate precipitation. The presence of magnesium and ammonia in the stone is said to indicate formation in the presence of infection.

It is often hard to tell which came first,

the stone or the infection, because each predisposes to the other. The elimination of hypercalciuria and utilization of stone analysis will accomplish much in solving this question.

Urinary Tract Infection

Infection deserves inclusion here because of its role in causing stones. Of our last 80 consecutive stone patients, 26 manifested urinary infection. It was a decided complicating factor in the two cases of proved hyperparathyroid disease. In some, the infection was cleared up along with the stones by nephrectomy.

It is helpful, although not always practical, to know if one kidney or both are infected, or whether the lower urinary tract alone is producing the pyuria. If retrograde studies are done in the course of handling the immediate stone problem, appropriate cultures are taken. Or if it is of some importance in deciding long term management, retrograde catheterization is done for this specific reason. For example, a man may demonstrate pyuria and his x-ray show several small stones in each kidney. The pyuria may come solely from a chronic prostatitis, and when this is known, one would not seriously consider infection as a factor in the stone formation.

After the stone is removed from an infected portion of the urinary tract, it is extremely worthwhile to stamp out the infection. Sometimes it will appear to clear up spontaneously. But when a chronic pyelonephritis has probably existed for some time and granulations have been built to protect the bacteria, it is a difficult task to gain this objective. One is probably helped by getting sensitivities to available antibiotics and by utilizing those drugs which are indicated. More often than not, short term antibiotic therapy will fail. At the present time in these cases, we are employing a rotation of several antibiotics continuously over a period of months. It is too early to tell how worthwhile this will be.

When stone and infection coexist, the hope of wiping out the infection without removing the stone is extremely dismal. We are sometimes tempted to remove stones from infected kidneys even at the risk of considerable trauma to the kidney in order to improve the chances of overcoming pyelonephritis.

Urinary Colloids

Recently there has been work done on the urinary colloid problem in reference to stone formation. As yet there seems to be insufficient evidence that stone-formers are lacking significantly in colloid, and therefor this element in the possible etiology of stones remains highly theoretical. The idea is receiving a great deal of attention, and careful investigation, and before long its role may be better defined.

Other Considerations

Abnormal puddling or decreased current, of course, contributes to stone formation, usually in conjunction with its secondary infection. This probably explains most bladder stones, which are almost always accompanied by residual bladder urine. The urologist glitters preeminently in the solution of this problem, and the subject is fairly well understood and usually adequately treated.

Nutritional factors, notably vitamin deficiencies, may account for the extensive stone formation in some areas of the far and near east. The modality appears to be localized injury or alteration in the urinary collecting epithelium, although the colloid problem remains a great unknown. It hardly seems important as a factor in this well-fed country.

Summary and Practical Measures

(1) Given a stone in the urinary tract, one solves the immediate problem which results from obstruction or irritation.

(2) The type of stone is determined.

(3) If a calcium stone is present, hypercalciuria is looked for and corrected if possible. Measures to decrease urinary calcium and phosphorus or aid in solubility of the latter are pursued when indicated.

(4) If a uric acid or cystine stone is present, the disease is recognized and preventive measures undertaken.

(5) Urinary tract infection is looked for and treated.

(6) Dilution of urinary crystalloids is maintained by a voluminous output when indicated.

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Certain Aspects of Pelvic Pain*

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Pain is the most common complaint which brings the patient to his physician. This symptom occurring in the lower abdomen and pelvis may have a wide range of etiologic factors and may constitute a problem in diagnosis of the first magnitude.

It would be possible to consider pelvic pain purely from the viewpoint of pain mechanism and the reflex neurologic processes which occur. I am ill-qualified to render such a discussion worthwhile, and I feel that such a consideration would have relatively little clinical importance to the practicing physician.

Another approach to the consideration of abdomino-pelvic pain would logically be by means of a classification as to the sites of origin and the type of etiologic agents which are productive of the symptom. For example, the various abdominal crises which may arise without previous warning, would include ruptured extrauterine pregnancy, gall bladder or renal colic, ruptured viscus, tabes, lead colic, coronary thrombosis, etc. Inflammatory causes would constitute another group with a consideration of inflammatory lesions of the tubes, uterus and ovaries, and various adjacent structures within the pelvis, namely, the rectum and the bladder.

Further, we could consider pelvic pain as it arises from complications of pregnancy; from various tumors, arising either in the reproductive organs themselves or in contiguous structures; from various types of traumatic disease, including old lacerations and malpositions of certain of the pelvic organs; and from a group of intestinal diseases or conditions productive of abdomino-pelvic pain, which would include appendicitis, colitis, typhoid fever, dysentery, hemorrhoids, fissures and fistulas.

There are also various functional abnormalities of the bowel, such as irritable colon, constipation, etc. In such a general consideration, one would also have to include diseases of the urinary tract, involving the kidney, the bladder and the urethra. Finally, such a categorical discussion would also include various nervous conditions which might incite pelvic pain such as myelitis and lead poisoning.

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In order to adequately discuss these entities in any satisfactory detail, many hours would be required, and perhaps in the long run, little value would be obtained because of the complexity of such an approach. It is my purpose rather, to consider some of the more common pelvic disorders productive of pain, the diagnosis of which will be little aided by laboratory studies, but which on the other hand will be greatly augmented by consideration of the woman and certain environmental factors of stress which exist in our culture.

Conservatism in Pelvic Surgery

It is my impression that conservatism in pelvic treatment and particularly conservatism in pelvic surgery, is a function to be carried out in the office and not a function of the pelvic surgeon to be carried out in the operating room. It is the exception rather than the rule, that the surgeon will open the abdomen for undiagnosed pain somewhere in the pelvis, find no disease of the abdominal or pelvic viscera, close the abdomen, approach the woman's husband and tell him that he did a fine operation and no disease was found, and in fact his wife's internal organs were in perfect condition. Such a conclusion is very poorly understood by the laity, and is always a source of embarrassment to the operator. It is my very distinct impression that exploration of the abdomen and pelvis for pain alone, seldom results in the identification of any pathologic process, and when pain is unassociated with a mass or evidence of an inflammatory process of any type, tumors, cysts, etc., an operation for its relief is usually not justifiable.

It is of significance that the great majority of diseases in the pelvis which give pain are symptomatic anteriorly over an area very little higher than a hand's breadth above the symphysis, and that backache due to a pelvic pathologic process rarely involves an area higher than a hand's breadth above the sacro-coccygeal junction posteriorly. The approach to the relief of lumbar backache, headaches, upper abdominal pain, soreness under the ribs, headaches and nervousness through various types of pelvic manipulations, either medical or surgical, is usually fruitless. A conclusion, therefore, as to the general nature of the problem involved should

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be reached by office investigation rather than by surgical exploration. It is of importance then, that some insight into the problems which are productive of pelvic pain in the absence of diagnosable pelvic disease be a part of the physician's armamentarium if he accepts the adult female for a patient.

Among the various types of complaints which fall into this large group of patients with pain, should be included certain types of dysmenorrhea, certain cases of dyspareunia and of hysteria which results in complaints of pelvic discomfort if the term can be applied in its broadest sense. Many of these patients are chronic complainers; they have shifted from doctor to doctor; they have tried large numbers of remedies, some of their own accord, and many times at the suggestion of a physician. They have had many types of injections by both the physician and his nurse; they have had numerous piecemeal pelvic surgical procedures, with a small cyst punctured here, the uterus suspended there, and an adhesion severed in another hospital. They are frequently of great concern to themselves, to their families and are quite likely to be annoying to the physician who is currently making efforts to treat them. Unfortunately, there are an insufficient number of gynecologists to see these people and even if consultation could be obtained in all instances, it would be of limited value because of the specialist's lack of information of the home situation which may be contributing to the patient's ills. It therefore, is not only the responsibility of the physician in the patient's own locality, but is an opportunity for him to better evaluate the complaint, to understand the complex nature of certain environmental factors as they apply in the individual case, and therefore, in the long run to give more adequate therapy.

Dysmenorrhea

Approximately one-third to one-half of all women have the complaint of pain with menstrual periods. A small minority of this group has a disease which has been acquired during adult life, which produces what is termed secondary or acquired dysmenorrhea. The symptomatology is usually that of increasing pain with each period and a tendency for the pain to be much more severe on the last day of flow than at the time the period starts. The patient can gradually become incapacitated and careful examination will reveal the presence of an inflammatory disease in the pelvis, endometriosis, submucous myoma, or some easily detected pathologic process which is productive of the menstrual pain. The treatment of this type of dysmenorrhea is either the surgical or the medical management of the underlying cause, rather than the treatment of the symptom of pain itself. Such cases are easily treated because the disease is apparent on careful investigation.

The much more common type of dysmenorrhea, primary dysmenorrhea, idiopathic or essential dysmenorrhea all terms meaning the menstrual cramps, unassociated with evidence of any disease in the pelvis is a condition which assumes importance not only to medical men, but also to employers of large groups of women and to administrators of various types of schools and institutions. The disability from primary dysmenorrhea has been studied by many authorities and time lost from work is of true economic importance in many industries. This type of dysmenorrhea is characterized by pain which had its origin usually at the time of the first menstrual period and which has remained approximately at the same degree of intensity with each subsequent period. The pain is usually worse just before or at the onset of the flow, improves by the second or third day and has disappeared by the time the flow has ended. It usually is associated with the so-called pre-menstrual tension syndrome which includes swelling of the abdomen, painful breasts, headaches, at times nausea, diarrhea, irritability, restlessness and sleeplessness. The pelvic pain is of a cramping nature similar to labor in its character and distribution, being referred to the back in a high percentage of instances.

It is my feeling that primary dysmenorrhea has two distinct components, one physiologic the other environmental, and it is for this reason that some consideration of the emotional maturation of women in our culture is in order. At the time the girl is born and during her early childhood, she has little if any idea as to the difference between the vaginal, the anal and the urethral openings. It is quite common, therefore, in her very impressionable early years that she gains the impression that the pelvic area is reserved for the purpose of excretion of certain objectionable products which require discarding by flushing down the commode. It is not unusual for the mother, as the child grows older, to bathe the child and when the area of the pelvis is reached, to hand a

washcloth to the child and tell her to bathe that part herself, thereby, further fixing in the child's mind a strong anal component in her impression of the genital region.

Psychosexual Influence

As the girl becomes somewhat more advanced, there are many repressions of a psychosexual nature which are automatically placed on her which have a far reaching effect with regard to future pelvic functions. Such impressions are gained through parental influence and also elementary school and Sunday school, so that by the time the child reaches puberty, her insecurity concerning mature feminine functions is of considerable extent. If the little girl is caught stealing an apple from the corner fruit stand, any reasonably good father will reprimand the child for her actions and go pay the fruit vender for the apple. If the child does poorly in the school, the parents will either hire a tutor, see the teacher or make strong recommendations in the Parent Teacher Society for an improvement in teaching techniques. But if the girl in her early years of maturity should conceive out of wedlock as an expression of relatively uninhibited fundamental female desires, it is the rare parent indeed who does not express wrath even to the point of ostracizing the child or at least making her feel unworthy and unwelcome as a loved one of the family circle, perhaps for years to come. Even the early masturbatory activities of the girl are not dismissed with the same attitude that thumb-sucking, ear pulling and other investigative or explorative activities are dismissed. It is therefore, uncommon that the girl is adequately prepared for pleasant pelvic experiences, much less for unpleasant menstruation, and the first period frequently is a most traumatic experience. These various repressions which are placed on the child in our culture are easily identified by the procedures which are common with regard to the management of menstruation itself. For example, there are many types of nationally advertised powders and lotions which are used to socially sterilize the pelvis at the time of menstruation in order to reduce the amount of odor which is supposed to be present in the vicinity of the menstruating woman. Although the blood which comes from the cervix at the time of a period, is sterile and has the odor of blood which arises from any place in the body, such is not recognized by many people at the present time. There are many terms which are used to refer to the menstrual period which lend an unhealthy connotation to the process of menstruation. "Cramps," to be "sick," to be "unwell," and even in the Scriptures, menstruation is termed the "curse" of woman. Further, the current methods for providing facilities for perineal care at the time of a menstrual period are unique; whereas toilet tissue is sold in a number of pastel shades, displayed in the most convenient and obvious location in the bathroom, and occasionally dispensed by a gadget with a concealed music box to play a tune when it is unrolled, menstrual pads are never left in sight and, when one is discarded, it is usually wrapped in volumes of paper and cautiously tucked away in the bottom corner of the wastebasket so that no one may observe it. All the ideas that a woman is more sensitive to cold, that she is more sensitive to heat, that her hair will not take a curl, that she will catch cold easier, that her period will stop if she gets wet, or that she will flood if she gets hot, are common knowledge and represent still further the cultural pattern which exists in regard to this physiologic function. It therefore seems impossible to me that many women can approach maturity and the first menstrual period without having a feeling that this is a messy business which is productive of pain, which it would be best to avoid, and which certainly must be concealed if it cannot be avoided. Restricted activities such as denying tub baths, of putting the girl to bed with a hot water bottle while the father fans and the mother calls the doctor is a picture with which you are just as familiar as I.

Physiologic Components

The physiologic component of primary dysmenorrhea has to do with two essential changes which occur at the time or near the time of menstruation. It is well known that at the time of the highest estrogen levels during the last few months of pregnancy and in the week preceding normal menstruation, there is a disturbance of the utilization and excretion of the sodium ion. Many women are intolerant to even small amounts of salt at this time and this results in fluid storage with an average or excess sodium intake in the form of salt, which is largely responsible for pre-menstrual tension.

The uterine activity which causes pain can be gauged by using an intrauterine balloon attached to a kymographic record. It is found to have an increase in the amplitude of contraction, with a tendency to-

ward spasm between the high waves of contraction. This results in labor like pains which are usually the chief complaint. By listening to the history of the patient, examining her pelvis carefully, reassuring her as to the normal and physiologic process of menstruation, by letting her know that her pelvic organs are indeed normal, that she need not restrict her activities, but that she will obtain a better flow, a freer flow with less pain if she is more active rather than less active and by prescribing some type of flexion exercises, to eliminate excess sodium prior to the periods, to treat the problem as a whole, frequently result in marked improvement or complete alleviation of primary dysmenorrhea. Mood improving drugs which are currently available and anti-spasmodics are of much more help than strong sedatives. The use of narcotics at the time of menstruation is not justifiable. It should be pointed out that there is no relationship between high educational attainment in a family, the relative social station of the parents, the degree of intelligence of the individual with regard to dysmenorrhea. The physician, whose authority in these matters is seldom questioned, has a unique opportunity in the treatment of this type of problem, if he will be kind, patient and authoritative.

Frigidity and Dyspareunia

Frigidity, or a lack of normal response to the sexual approach of the male frequently results in symptoms of pelvic pain. Whereas, the patient is hesitant to come with a chief complaint of frigidity, such a problem is often presented under the guise of pelvic pain, backache, headache, weakness and neurasthenia. By approaching the problem in its broader aspects and taking a general history of the menstrual period, the number of children, how the symptoms occur, whether they are related to sexual relations, will give an opportunity to the patient to verbalize and frequently she will show an unexpected willingness to reveal the true nature of what is bothering her. Those patients with relative frigidity will frequently be relieved of the painful aspects of their complaint through counselling with the physician who is willing to discuss these matters in an open minded and direct fashion. Unfortunately, a certain number have such involved problems in the psychosexual realm that total frigidity with a complete lack of interest and a feeling of disgust concerning sexuality and all of its implications, must be treated by prolonged psycho-therapeutic methods. Those with relative frigidity, however, can be helped tremendously by any physician who is willing to devote the time necessary to their problems.

Dyspareunia, although not synonymous with frigidity, may be the result of a pathologic process in the pelvis, but it may also be a defense mechanism and a method of disguise of a fundamental psychosexual disturbance. The differential diagnosis can be made by a simple pelvic examination.

It is unfair to a physician and to his other patients to take the necessary time in the midst of a busy office schedule to discuss the details of this type of problem with the patient and perhaps with her husband. For many years it has been customary for doctors who have elective surgical procedures to carry out, to make the schedule from a few days to a week or more in advance of the time of the contemplated operation. It is my strong feeling that some similar plan may be carried out to relieve the stress on the physician and to render better service with regard to the chronic complainers who come into the office and who require more time than they can ordinarily be given. I feel that almost any physician could reserve an hour or two during the course of a week and if problems of this kind arise during the regular office hours, the detailed discussion of them may be deferred until then. At this time he will be able to discuss with the patient and other members of the family if necessary, the nature of the difficulty. The doctor is more at ease under these circumstances, the patient realizes that he is not in a hurry, and the results will be much more satisfactory. There is little doubt that many unnecessary operative procedures of suspension of the uterus, puncturing of cysts, insertion of pessarys in the cervix, would be avoided and many fewer hormone and vitamin preparations by injection would be employed.

In Conclusion

Conservatism in the management of the chronic type of pelvic pain justifies whatever effort is required on the part of both the patient and her doctor in order that no unnecessary operative procedures be carried out. A very famous gynecologist once said that if every man regarded the female reproductive system with the same type of surgical respect that he would desire a colleague to have in regard to his own genital apparatus, no unnecessary pelvic surgery would be performed.

An Indication of the Incidence of Blastomycosis in Central Kentucky

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It has long been recognized that Kentucky is located in the center of a large area endemic for histoplasmosis. This has been well established by the research and epidemiological studies of several groups, in Tennessee (Zeidberg, Dillon and Gass, 1951), the United States Public Health Service (Grayson and Furcalow, 1953) and in Kentucky (Kotcher and Leikin, 1950) (Robinson and Kotcher, 1951) (Menges, McClellan and Ausherman, 1945).

However, until recently, except for the latter mentioned report, there has been little or no attention given to a closely related mycotic disease—North American Blastomycosis. The prevailing opinion has been that blastomycosis occurs in this area as somewhat of a rarity. In 1954, Menges, McClellan and Ausherman presented the results of a study of canine histoplasmosis and blastomycosis in Fayette and the adjacent counties of Kentucky. They listed a series of 23 cases of histoplasmosis and seven cases of blastomycosis from 1947 to the beginning of 1953. While there was no evidence of an epizootic of blastomycosis in dogs it was felt that the incidence was more than just occasional and that further investigation of the incidence of blastomycosis in man and animals was warranted.

Source of Cases

This report is concerned with such a study. It deals with the incidence of human blastomycosis in Central Kentucky in the past seven years and with an additional number of cases of canine blastomycosis diagnosed in 1953. The data presented in this report are limited to the study of patients and specimens seen at the Lexington Clinic. Since relatively fewer patients come to this clinic from eastern and western Kentucky, we have not had material indicating the incidence of blastomycosis in these areas. It should be emphasized that this study is merely an indication of the incidence of blastomycosis because we are certain there have been several proved cases of the disease which have not been brought to our attention. We also believe, that because of the tendency of blastomycosis to simulate a pyogenic abscess or a chronic disease such as tuberculosis, the possibility of undiagnosed cases of blastomycosis exists.

In each of the cases we are presenting the diagnosis of the disease was established by recognition of typical blastomycotic budding cells in an exudate or in tissue sections, or by culturing the material from an inflammatory process and obtaining a growth of *Blastomyces dermatiditis*, or by both tissue sections and cultures.

The cases of human blastomycosis in this report conveniently fall into three categories—blastomycosis of the skin, bone, and systemic involvement. While it is generally conceded that cutaneous lesions are primary ones, there has been some evidence that cutaneous blastomycosis may be secondary to pulmonary involvement (Schwarz and Baum, 1951). In the 11 cases of cutaneous blastomycosis we are presenting there was no evidence of pulmonary disease. In general the skin lesions grow slowly, attain a certain size and then extension into the deeper tissue follows with a hematogenous or lymphatic dissemination if untreated. For a more detailed description of the gross and microscopic appearance of the cutaneous lesion the reader is referred to the publications by Schwarz and Baum (1951), Ormsby and Montgomery (1948) and Conant et al (1954).

Case Reports

The cases of cutaneous blastomycosis are as follows (when known, the race and age of the patient are stated in each case):

Case 1. 1947. A white female from Montgomery County with a cutaneous lesion on the right forearm which, on biopsy, showed intradermal abscesses with budding blastomycotic cells.

Case 2. 1947. An 87 year old while male from Fayette County with an ulcerated lesion on the ankle which was excised and on tissue section showed budding cells of blastomycetes.

Case 3. 1948. A 59 year old white female

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from Montgomery County with small epithelial abscesses on the right cheek which were excised and on section showed typical blastomycetes cells.

Case 4. 1948. A 24 year old male from Bell County with multiple abscesses and inflammatory areas on the shoulder, face and hip. Tissue biopsies taken from several sites revealed budding blastomycotic cells.

Case 5. 1948. A 67 year old white male from Fayette County with a chronic cutaneous abscess on the right forearm. Biopsy showed typical budding cells of blastomycetes.

Case 6. 1949. A 45 year old white male from Perry County complained of several ulcerated lesions on the left leg which had drained persistently for two and one-half years despite the fact that the lesions had been incised several times. Examination of the purulent exudate revealed typical blastomycotic cells. The patient was placed on iodine therapy and the ulcers were widely excised and cauterized, resulting in healing of the lesions and disappearance of the organisms from the site.

Case 7. 1953. A 39 year old male from Bath County with a cutaneous lesion on the left knee which was biopsied and, on section, showed chronic inflammation and foreign body giant cells with fibroblastic and lymphocytic infiltration. Throughout the sections numerous budding cells of blastomycetes were seen.

Case 8. 1953. A 36 year old white male from Fayette County with a chronic lesion on the right arm. Tissue sections showed chronic inflammation with foreign body giant cell formation and many blastomycotic organisms.

Case 9. 1953. A male from Harrison County with an ulcerated lesion on the leg which was excised and sectioned. The sections revealed chronic inflammation with occasional blastomycotic cells observed.

Case 10. 1953. A 56 year old colored male from Lincoln County with a lesion above the left eye. A biopsy of this lesion showed many chronically inflamed micro-abscesses with numerous budding blastomycotic cells.

Case 11. 1953. A 46 year old white male from Harrison County with a cutaneous lesion below the left mandible which had drained persistently and failed to respond to antibiotic therapy. Wet mounts of the exudate revealed many budding blastomycetes and cultures of the exudate gave a growth identified as *Blastomyces dermatiditis.*

These cases clearly indicate that any chronic, crusting, purulent, skin lesion should be examined for blastomycetes as part of the routine pathological examination. Also, it appears advisable to consider skin lesions due to blastomycosis as being secondary until proved otherwise and a thorough examination for the primary site should be made.

Two cases of blastomycotic osteomyelitis are included in our survey.

Case 12. 1952. A 46 year old white female from Montgomery County with a suspected neoplasm of the femur. A biopsy indicated that a neoplasm was not present but showed fibrous tissue replacement with extensive necrosis and suppuration. Throughout the lesion many blastomycotic cells were observed.

Case 13. 1953. A 27 year old white male from Fleming County complained of swelling of the left thigh just above the knee. Roentgenograms indicated that the lesion had penetrated to the femur causing an osteomyelitis. Biopsy showed necrotic bone with many blastomycotic organisms. Cultures of the biopsied

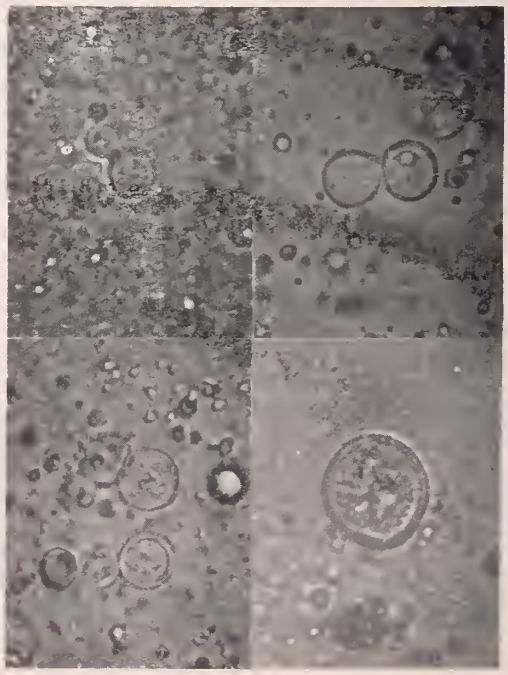


Figure 1

Figure 1 shows the yeast-like phase of Blastomyces dermatiditis. The cells are in various stages of budding and the double contured cell wall is easily observed.

material gave a growth of *B. dermatiditis*. A surgical saucerization of the femur was performed and the patient placed on stilbamidine therapy. At the last examination the case appeared to be arrested.

Clinically, the most interesting cases in our survey were four cases of systemic blastomycosis. Because there appears to be no general pattern of systemic dissemination and because any organ may become involved, these cases are presented in greater detail.

Case 14 1948. A 50 year old white male from Owsley County who complained of soreness in the upper chest marked by acute pain and cough. A chest x-ray was taken which failed to reveal any significant findings. Shortly after his initial examination the patient developed wide spread subcutaneous nodules on the face, hands and body. Several of these nodules were biopsied and after careful search, typical budding blastomycotic cells were observed. The patient was then placed on extensive iodine therapy. The patient died in 1950 but the cause of death was not determined.

Case 15. 1951. A 44 year old colored male from Fayette County was in good health until three months prior to his admission to the hospital. The history revealed that the patient had injured his left hand in a street fight. The patient's chief complaints were severe headaches, back pain, generalized weakness and a progressive weight loss. He had also developed a cough productive of a blood tinged sputum. Chest x-rays were reported as being consistent with that of tuberculosis with cavitation. A clinical diagnosis of disseminating miliary tuberculosis and tubercular meningitis was considered to be most probable. The patient became progressively worse and died on the nineteenth hospital day. An autopsy was performed and on gross examination all of the lesions found in the lungs, liver and spleen were similar to what might be found in tuberculosis but none of the lesions found anywhere showed histological resemblance to lesions of tuberculosis. On the contrary, budding yeast-like organisms identified

Case No.	Year	Age	Sex	Race	County	Site of Lesion	Diagnosed by
1	1947	?	F	W	Montgomery	Cutaneous right forearm	Tissue section
2	1947	87	M	W	Fayette	Cutaneous ankle	Tissue section
3	1948	59	F	W	Montgomery	Cutaneous	Tissue section
4	1948	24	M	?	Bell	Cutaneous shoulder, face, hip	Tissue section
5	1948	67	M	W	Fayette	Cutaneous right forearm	Tissue section
6	1949	45	M	W	Perry	Cutaneous left leg	Wet mount
7	1953	39	M	?	Bath	Cutaneous left knee	Tissue section
8	1953	36	M	W	Fayette	Cutaneous right arm	Tissue section
9	1953	?	M	?	Harrison	Cutaneous leg	Tissue section
10	1953	56	M	C	Lincoln	Cutaneous left eye	Tissue section
11	1953	46	M	W	Harrison	Cutaneous left mandible	Wet mount and culture
12	1952	46	F	W	Montgomery	Bone femur	Tissue section
13	1953	27	M	W	Fleming	Bone left thigh	Tissue section and culture
14	1948	50	M	W	Owsley	Systemic and cutaneous	Tissue section
15	1951	44	M	C	Fayette	Systemic	Autopsy
16	1952	63	M	W	Woodford	Systemic	Wet mount and autopsy
17	1952	50	F	W	Fayette	Systemic and cutaneous	Wet mount and culture

Figure 2

A tabulation of 17 cases of human blastomycosis occurring in Central Kentucky from 1947 to 1954.

as blastomycetes were found in the meninges, calvarium, lumbar spine, lungs and skin of the left hand. This is case number 32 of Menges, et al. (1954).

Case 16. 1952. A 63 year old white male from Woodford County sought medical attention for a draining ulcer at the base of the fourth finger of the right hand. Laboratory examination of the pus from this lesion showed typical blastomycotic cells. The ulcer was saucerized and the patient was placed on stilbamidine therapy. Six months later the patient began to have shooting pains throughout the right side of his head and right ear. He was hospitalized and placed on combined iodine and stilbamidine therapy. His condition gradually worsened; he became incoherent and comatose and died after being in the hospital one month. The autopsy showed the cause of death to be due to disseminating blastomycosis of the lungs and meninges with an internal blastomycotic hydrocephalus. This is case number 33 of Menges et al. (1954).

Case 17. 1952. A 50 year old white female from Fayette County whose chief complaint was a painful, tender swelling in the left hand associated with a purulent drainage. A similar painful, tender area also had developed in the left leg. Microscopic examination of the pus revealed typical budding blastomycotic cells. Examination of several sputum specimens also showed typical budding blastomycosis cells which, on culture, were identified as *B. dermatiditis*. X-ray also indicated extensive osseous involvement of the left hand, arm and leg. The patient was given an extensive course of treatment with stilbamidine while in the hospital and as an out-patient. Seven months later the patient was readmitted to the hospital complaining of numbness in the face. Dental examination indicated that the remaining teeth had become abscessed and required extraction. Sputum examination at this time still gave positive cultures of *B. dermatiditis*. Stilbamidine therapy was again started and after a three month period sputum cultures were consistently negative for blastomycetes. This patient showed no evidence of blastomycosis for approximately 14 months at which time she again sought medical attention for a small subcutaneous abscess on the lateral aspect of the right forearm. The drainage from this abscess showed typical blastomycotic cells and also gave a growth of blastomycetes. At the time of writing, this patient is under observation and treatment for blastomycosis and is in apparent good health. This is case number 34 of Menges et al. (1954).

Canine Blastomycosis

We would like to include in this report our findings on canine blastomycosis. In 1953 we found seven cases of blastomycosis in dogs. The number of cases found in one year equals that reported by Menges, McClellan and Ausherman over a five year period. Each case of this disease in dogs was characterized by a harsh chronic cough and terminated fatally or the dog was destroyed following diagnosis. At autopsy, all animals showed a nodular type of lung lesions and a marked enlargement of the lymph nodes located at the bifurcation of the trachea. The enlarged nodes caused compression of the trachea, often decreasing the size of the lumen to a narrow slit. The lymph nodes were necrotic and fibrotic yet calcification was lacking and in one case minimal.

The accompanying photographs show typical stages of the yeast-like phase of *Blastomyces dermatiditis*. The observation of double contoured, single-budding, yeast-like cells in a suspicious exudate or sputum is considered pathognomonic and is usually ample evidence for a diagnosis of blastomycosis. However, it should be remembered that confusion with some of the other yeast-like fungus cells, *Monilia, Cryptococcus, Blastomyces braziliensis* and *Coccidioides*, may occur. Therefore, it is highly desirable that confirmatory identification by proper cultures on appropriate media be done whenever possible. In connection with the cultivation of *B. dermatiditis*, incubation should be at both room temperature and 37 C. as the fungus is biphasic, giving a mycelial growth at room temperature and a yeast-like growth at 37 C.

The 17 cases of human blastomycosis presented in this paper have been tabulated in Fig. 2 and their geographical distribution has been plotted in Fig. 3.

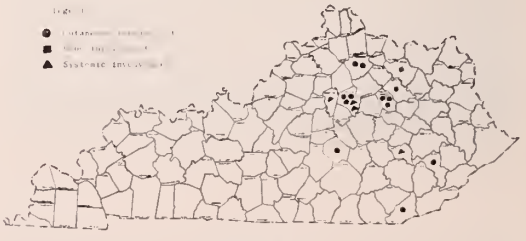


Figure 3

The Geographical distribution by county of 17 cases of human blastomycosis occurring in Central Kentucky from 1947 to 1954.

It is not possible for us to state with any degree of accuracy the incidence of blastomycosis in Kentucky but we do feel that these cases amply demonstrate that the disease is by no means a rarely occurring infection. On the contrary, it is our contention that a more extensive survey would yield data sufficient to label this area endemic for blastomycosis. In commenting on the incidence of canine blastomycosis it is indeed tempting to speculate on the possible relation between the occurrence of the disease in man and dogs. There is as yet no evidence to support a theory of transmission of blastomycosis from animal to man or vice versa nor is there any data to indicate the natural occurence of the causative organism. A common denominator undoubtedly exists. It remains for additional research to find this common denominator.

Summary

In summary, we have presented 17 proved cases of human blastomycosis that occurred in Kentucky from 1947 to 1954. These cases were all diagnosed in our laboratory and indicate that blastomycosis is a widely prevalent disease in Kentucky. The means of diagnosis, pathology and extent of the disease in each case is presented. Seven cases of canine blastomycosis are also presented. No evidence was obtained to support a theory of transmission of this disease from animal to man.

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Anticoagulants in the Treatment of Acute Myocardial Infarction: Analysis of 115 Attacks*

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The thromboembolic complications of acute myocardial infarction, namely: pulmonary embolism and infarction; cerebral vascular embolism, or thrombosis; subsequent myocardial infarction within two to three weeks; thrombosis and embolism of a peripheral artery and thrombo-phlebitis are of such severity as to influence the immediate mortality[1].

The routine use of anticoagulants, barring specific contraindications, to prevent such thromboembolic complications was encouraged by the Report of the Committee for the Evaluation of Anticoagulants in the Treatment of Coronary Thrombosis with Myocardial Infarction appointed by the American Heart Association. In a summary of the findings for 1031 cases[2], it was reported that anticoagulants exert a markedly favorable influence on the thromboembolic complication rate associated with myocardial infarction for cases that survive the initial impact of the attack. Twenty-six per cent of 442 control cases developed thromboembolic complications during the six-week period of observation as contrasted with only eleven per cent of the 589 treated cases. Others have reported similar observations. A complete review of the literature was made by Kerwin[3].

This report is a study of the use of anticoagulants by the staff of a private hospital in Louisville. It includes a consecutive series of patients with the proved diagnosis of acute myocardial infarction. No case was included unless the electrocardiogram revealed the characteristic changes. Only patients were selected who entered the hospital within three days of the attack. Moreover, all patients who died within three days of admission to the hospital were excluded. Also only those patients were included who had therapy for at least two weeks. Dicumarol, without heparin, was principally used, and all the physicians administered daily doses in an

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attempt to keep the blood prothrombin times to within 15 - 35 per cent of normal.

A total of 115 attacks in 109 patients were analyzed. Table 1 gives the age and sex incidence. There were 82 men and 27 women. The ages ranged from 38 to 79 years. The majority were in the fifth. sixth and seventh decades. This is the usual age and sex incidence of the disease.

Thromboembolic complications occurred in only two (1.0 per cent) of the 115 attacks. Case I—A fifty-two-year-old male had another myocardial infarction seven days after the initial attack, at a time when the prothrombin time was 36 per cent of normal; Case II—In a sixty-six-year-old male, dicumarol was discontinued after fifteen days of administration; a month later there occured a left hemiplegia, considered to be due to a cerebral embolism, with death in six days.

Of the 109 adequately treated patients, only four died during the first two months after the onset of the infarction. Table II lists the type of death.

In 20 patients, not included in the total of 109 analyzed, dicumarol was stopped before the two-week minimum period of treatment because of hemorrhage or death or discharge from the hospital. Eleven of these patients died, having received dicumarol from one to eleven days..

Hemorrhagic complications were of minor statistical importance. In 129 patients hematamesis occurred in one; tarry stools occurred in two; epistaxsis once and gross hematuria occurred in two other cases. No attempt was made to determine the incidence of microscopic hematuria. It is important to remember that hemorrhages can occur in patients with a myocardial infarction who have not received anticoagulants.

TABLE I

AGE AND SEX INCIDENCE

(109 Cases)

Age	Male	Female	Total
30 - 39	6	0	6
40 - 49	18	2	20
50 - 59	27	6	33
60 - 69	22	12	34
70 - 79	9	7	16
Total	82	27	109

TABLE II

MODE OF DEATH

(Four Cases)

Days After Admission	Type of Death	Previous Myocardial Infarction
16	Sudden	Yes
35	Uremia	No
14	Sudden	No
44	Cerebral	No

Discussion

The routine use of anticoagulants in the treatment of acute myocardial infarction has been questioned. Rytand[4] attempted to critically interpret the data of the Anti-Coagulant Committee of the American Heart Association and other reports and felt that there were serious defects in the claims of the proponents of routine anticoagulant therapy in the management of acute myocardial infarction. He felt that such drugs may have some value but that there was no valid evidence that prognosis for immediate survival was improved. It is our opinion, from a review of the literature and the results of our own study, that the routine use of anticoagulants in acute myocardial infarction is valuable in that it decreases the incidence of thromboembolic complications. This assumes that there are no contraindications to the use of such drugs.

Using "prognostic criteria" Russek et al[5] have attempted to evaluate therapy by classifying patients who have had an acute myocardial infarction into "good risks" and "poor risks." Since thromboembolism occurred in 10.6 per cent of the "poor risks" and only 0.8 per cent of the "good risk" cases, they conclude that anticoagulants should be given only those who are "poor risks." Furman et al[6] using slightly different "prognostic criteria" found that the beneficial effects of anticoagulants were most apparent in the "poor risk" group of patients. We agree with Wright[2] and others that clinical experience does not warrant the recommendation of treating only patients appearing severely ill at the onset. No one can predict when a mild case will become severely ill or will have thromboembolic complications.

Conclusion

Anticoagulants are indicated as a routine in the treatment of acute myocardial infarction.

(The author wishes to acknowledge with gratitude the help of Mr. Wendell Burns, Senior Student, University of Louisville School of Medicine.)

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Basal Cell and Squamous Cell Carcinoma of the Skin

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Carcinoma of the skin is the most common type of cancer and is often seen in individuals with light complexions, particularly blondes with blue eyes. Farmers, sailors and other individuals exposed to the elements frequently develop epitheliomas. Carcinomas of the skin are more common in southern areas where there is more sunshine than in northern regions. Epitheliomas are frequently associated with poikiloderma, epidermodysplasia verricuformis and chronic lymphatic leukemia. Senile keratoses often degenerate into squamous cell epitheliomas. Seborrheic keratoses have been thought to give rise to epitheliomas. Occasionally carcinomas of the skin follow injury.

The typical picture is that of an elevated, indurated lesion with a pearly appearance. Telangiectases are frequently present. Older lesions may show ulceration and secondary infection. It is impossible to differentiate clinically between squamous cell carcinoma and basal cell carcinoma. Squamous cell carcinoma as a rule grows more rapidly and ulcerates faster than basal cell carcinoma. In differential diagnosis senile keratoses and Bowen's disease should be considered. Occasionally the clinical course will be similar to sporotrichosis, bromoderma, iododerma, blastomycosis and coccidioidomycosis.

Not infrequently verrucous, papillomatous or fungoid lesions are seen as well as extensive cauliflower-like growths. The latter are of a relatively low grade malignancy. Superficial ulcers, diffuse plaques, and nodules that are growing rapidly with or without extension to the adjacent lympth nodes are more likely to be grade 3 or 4 epitheliomas. Wilson[1] emphasized that the rate of ulceration is directly proportional to the degree of malignancy except in the case of lesions of grade 4 which ulcerate at a rate between that of grade 1 and grade 2.

Treatment

Many different forms of therapy have been investigated. Sullivan[2] used podophyllin in 20 cases of cutaneous carcinoma. Recurrences were observed in 15 of these cases during the first year after treatment. Amersbach, Walter and Sperti[3] treated 46 lesions with weekly injections of spleen and liver extracts, the total number of injections varying between 6 and 48. Two failed to respond, four were excised because of slow regression, five showed 50 per cent to 90 per cent regression when last seen and five were still under treatment at the time of writing.

Hughenia, Hebrand and Saracino[4] reported disappearance of one epithelioma while the patient was under nitrogen mustard therapy. Thorium X and Radon have been used successfully in the treatment of epitheliomas[5].

Low-Beer[6] was apparently highly successful in treating 52 basal cell carcinomas with radioactive phosphorus. In 46 of the cases there was only one treatment. Fifty-one of the lesions disappeared. No follow-up was reported.

Cautery, interstitial or external irradiation, surgery and combinations of these have been used for many years. In good hands these forms of therapy have often yielded good results. One particular type of therapy deserves special mention because of its consistent and high rate of success. The procedure consists of superficial biopsy followed by cautery, curettage and then irradiation by X-ray or radium needles. In a series of 461 cases reported by McKee and Cipollaro[7] relapse occurred in only 9 percent of cases which were cauterized, curetted and then treated by X-ray. Recurrence was found in 15 per cent of the cases in which X-ray was used alone.

A sufficient biopsy specimen may be ob-

tained in most cases by excising the lesion parallel with normal skin. By this method it is not necessary to go through the dermis and little if any scar remains. The lesion is then cauterized and curetted until all bleeding points and friable tissue disappear. This leaves a cauterized healthy base, and it is usually unnecessary to cauterize through the dermis to get to the base of basal and squamous cell carcinomas. As a result there is no scarring. The lesion should be cauterized for 0.5 to 1.0 cm. outside the area of visible involvement.

There are many different schedules and qualities of X-ray. The routine should be flexible, the quality of X-ray varying with the lesion. Deep infiltrating lesions should be treated with additional aluminum or copper filters. Coutard's theory, adhered to by many, is that malignant cells are most sensitive to X-ray when they are dividing and that fractional doses are preferable. X-ray administered every other day usually finds the cell in some phase of mitosis. The total dose is about 5,000r, administered 1,000r every other day or 500r daily.

Interstitial radium needles may be used in place of superficial X-ray therapy. The advantages of this form of therapy are 1) there is continuous bombardment of proliferating radiosensitive cells; 2) the irradiation is interstitial and does not have to pass through the epidermis; 3) two or three planes may be irradiated at one time; and 4) it is possible to give superficial irradiation in combination with interstitial irradiation. The needles are injected into the dermis or subcutaneous fat and left in place for from 7 to 10 days.

Most recurrences take place within one year and are more difficult to cure. In a series reported by McKee and Cipollaro[7] 30 per cent of the failures were in cases that had been previously treated. A biopsy is important because many recurrences show a mixed baso-squamous cell carcinoma which is more radio-resistant than either basal cell carcinoma or squamous cell carcinoma. It is important to see treated cases every month or two months for possible recurrence. Relapse may occur as late as 4 to 5 years after treatment.

Conclusion

A short review of the etiology and management of epitheliomas is presented. One highly successful procedure which leaves no scar consists of superficial biopsy followed by cautery, currettage, and then X-ray.

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The American Medical Association and the American Hospital Association have collaborated in developing a joint questionnaire designed to bring about greater uniformity in the reporting of annual hospital statistics which each organization obtains from hospitals, according to the AMA Washington office. This project is expected to provide helpful and much-needed hospital data this year.

The President and officers of the Jamaica Branch of the British Medical Association, British West Indies, are extending an invitation to all KSMA physicians attending the AMA Clinical Meeting in Miami, Florida, to attend a post-convention meeting of the BMA, December 4, 1954, at Kingston, capital city of the Island. Contact your KSMA Headquarters Office for further details.

Enactment of a military medical scholarship program is anticipated during the next session of Congress, according to Frank B. Berry, M. D., assistant secretary of defense (health and medical). Under the plan students would serve one year as physicians in the Armed Services for each scholarship year. A minimum of three years' active duty would be required of recipients because obligated draft services also would be counted as scholarship pay-off time.

The first public center in the United States for pure research in mental disease will be built in Indianapolis as part of Indiana's expanded program in this field, according to Governor George N. Craig. The enterprise, to be called the Psychiatric Research Foundation, will be set up in the Indiana University Medical Center.

CASE DISCUSSIONS

FROM THE LOUISVILLE GENERAL HOSPITAL

Afibrinogemia Associated With Abruptio Placenta

Presentation of the Case:

David Groenig, M. D.

History

This patient is a 23 year old colored para 2, gravida 3, whose last normal menstrual period was 20 October 1953, lasting four days. The estimated date of confinement was 27 July 1954.

Her first two pregnancies were uneventful. She had had no prenatal care with the present gestation.

At 6 p.m. 8 March 1954, the patient developed abdominal cramping described as "labor pains." A few hours later the pains became severe occurring every five to ten minutes. At 11 p. m. on the same day she noticed moderate vaginal bleeding. The pain and bleeding continued throughout the night and on the morning of 9 March 1954 she became "light headed" and felt "weak." The estimated blood loss by patient was "two or three cups."

Physical Findings

The patient reported to Emergency Room at noon on March 9, 1954. At this time examination revealed her temperature to be 98.8°, blood pressure 130/80 pulse of 86 per minute. Examination of heart and lungs was negative. The uterus was at the level of the umbilicus, and was very tender with strong contractions occurring every three to five minutes. The uterus did not relax completely between contractions. Vaginal bleeding at this time was moderate. Sterile vaginal examination revealed the cervix to be two fingers dilated, fifty per cent effaced with a bulging bag of waters. Fetal parts were felt behind the bag of waters. No fetal heart sounds were heard.

Laboratory Examination

The Hemoglobin on admission was reported as 9.6 grams with a Hematocrit of 31%. The white blood count was 21,400 with 92% polymorphonuclear leukocytes. The urine showed a one plus albumen.

Diagnosis

The clinical diagnosis of abruptio placenta and inevitable abortion was made. Intravenous fluids (1000 cc of normal saline) were begun, the bag of waters was ruptured artificially, and a Pitocin infusion (10 units of Pitocin in 1000 cc 5% dextrose) was administered very slowly.

Vaginal bleeding was at this time minimal. Examination of a venous blood sample obtained on admission failed to show any clot formation. Another 5 cc sample of the patient's blood was drawn and observed. After thirty minutes, there was no evidence of clot formation. This was thought to be a case of afibrinogenemia and a hematology consultation was immediately obtained. Efforts also were made to procure a supply of intravenous fibrinogen.

Course

During the interim, intravenous administration of whole citrated blood was begun. After 250 cc of blood had been given, the patient began to have heavy vaginal bleeding, and spontaneously delivered a twenty week fetus. The placenta followed immediately showing evidence of complete separation. The clots were expelled from the vagina and the uterus contracted well with the use of oxytocics. Bright vaginal bleeding continued in spite of the oxytocics. The uterine cavity was explored manually and was found to be empty without tears. During the following ten or fifteen minutes the measured blood loss was 2000 cc. By this time 1300 cc of whole citrated blood had been given intravenously. The blood pressure was 70/40 and the pulse was 140 per minute, very weak and barely perceptible.

2.4 grams of pure fibrinogen diluted with 200 cc of sterile water was then administered rapidly intravenously. Within ten minutes the vaginal bleeding had subsided. 2000 cc of whole citrated blood was given and very shortly the blood pressure rose to 130/90 with a pulse of 90 per minute and of good quality.

One and one half hours after the fibrinogen had been given, another sample of venous blood was drawn. It showed good clot formation in four minutes.

The patient did well throughout the night and was given an additional 500 cc

of whole citrated blood the following morning. Bleeding time was now four minutes and the clotting time six minutes. Her remaining post partum course was uneventful and she was discharged on her seventh post partum day.

Hematologic studies on the original blood samples revealed an absence of fibrinogen and failed to demonstrate a fibrolysin.

Glenn W. Bryant, M.D.

Department of Obstetrics and Gynecology

Afibrinogenemia is a recently recognized condition that is encountered in Obstetrics, usually associated with placenta abruptio. All cases of abruptio placenta should be considered as potential candidates for afibrinogenemia. The diagnosis is made by observing the failure of clot formation and retraction in a venous blood specimen. Specific treatment for this condition is the administration of fibrinogen along with adequate blood replacement.

All physicians treating obstetrical patients should be aware of this bleeding complication in association with abruptio placenta.

E. H. Sanneman, M.D.

Department of Hematology

The normal fibrinogen level of the blood varies from 200 - 400 mgms per 100 cc of plasma. During pregnancy there is a tendency for the fibrinogen level to be increased. The question then is raised, "What caused the patient to develop an absence of fibrinogen?"

It is known that amniotic fluid is thromboplastic. In abortion or in premature separation of the placenta, the thromboplastic substance of placental origin passes into the maternal circulation. The thromboplastic substance in the presence of calcium, initiates the conversion of prothrombin to thrombin. The thrombin then reacts with fibrinogen to form fibrin and intravascular clotting occurs. Since there is an excess of thromboplastic substance present, this reaction continues until fibrinogen and other coagulation proteins are consumed, with the ensuing development of a severe bleeding tendency due to afibrinogenemia.

Dr. Bryant has already discussed the rapid method of determining the absence of fibrinogen, and also the simple method of treatment.

O. J. Hayes, M.D.

Department of Obstetrics and Gynecology

As this case clearly shows, and as Dr. Bryant has brought out, the administration of fibrinogen intravenously is the accepted treatment of this condition. Whole blood is essential to replace the blood loss, but is a very poor means of replacing the fibrinogen deficiency. If whole blood must be depended upon alone, the direct method of transfusion is better for this condition than the use of citrated blood. In event of a case of afibrinogenemia, surgery should not be used to control post partum hemorrhage as the generalized oozing from all surfaces may be fatal.

SPECIAL ARTICLES

UNSOLVED PROBLEMS*

J. DUFFY HANCOCK, M.D.

Louisville

Because of its remarkable discoveries and its amazing achievements, medicine has been described in the past as a dynamic profession. Judged by its continuous efforts to make the present unsolved problems tomorrow's accomplished attainments, it is perhaps even more dynamic.

The type of presidential address will often be determined by the necessities of the day. It may be eulogistic or critical, philosophical or practical, political or socially minded. At the present time, it would seem most urgent to review with you our unsolved problems, most of them too familiar to all of us.

Distribution of Physicians

The paramount problem of course is an adequate supply of physicians, properly distributed throughout the state. Enlarging the Medical School at the University of Louisville or opening a new one at Lexington or both will not furnish the answer. Doubling the output of physicians in state schools means nothing if those physicians locate outside the state and it means very little if they locate in the larger centers of the state. Good doctors as well as good lawyers and dentists and teachers and preachers want decent living conditions. If satisfactory roads, utilities, schools, churches, hospitals and recreational facilities are provided, physicians will become available. While Kentucky has fewer physicians per capita than the national average, even so enough could be spared from the larger centers to give fairly adequate coverage. The law of supply and demand may bring about a partial solution to this difficulty. A contributing factor will be the Rural Scholarship Fund with its obligatory contract to practice in rural areas for a variable length of time. Another rather neglected policy is the requirement for medical students to serve clerkships in small hospitals, or preceptorships under rural physicians. Contacts thus renewed or established result in personal acquaintanceship with people in that community and may well persuade the young doctor to return.

This problem is like most of the others in that we alone cannot solve it. The community concerned has a corresponding obligation and must aid in the economic and social aspects of the question.

Medical Care of the Indigent and Medically Indigent

From a practical standpoint, there is little difference between the indigent and the medical indigent so far as medical care is concerned. The former is unable to meet his obligations in any way. He needs help for his rent, his school expenses, and his grocery bill as well as his medical care. The latter can live without assistance until illness stops his income or increases his usual expenditures. There are many reasons why some people are indigent or medically indigent. Careful studies are being made by various groups, including our own Association, into these causes and will be the subject of later reports by these committees. Our unsolved problem in this field is the challenge to see that these people receive adequate medical care when they are personally unable to pay for it. This philosophy did not originate with the New Deal nor the Fair Deal. It was an old American principle before either was heard of; and before America was discovered, it was exemplified by the action of the good Samaritan and by the dictum of the corporal works of mercy—to feed the hungry; give drink to the thirsty; clothe the naked; harbour the homeless; visit the sick; visit prisoners and ransom captives; bury the dead. Even in the Garden of Eden men were admonished to be their brother's keepers. With such precept and custom it is a sad commentary to observe the neglect so casually accepted in our own state. It is true that we have statutes to correct this situation on a county level. Unfortunately, it is equally true that many coun-

*Presidential Address, Kentucky State Medical Association, 1954 Annual Meeting, Louisville, Kentucky, September 23, 1954.

ties are too poor to finance necessary services. The consolidation of groups of counties would be most economical in eliminating duplicate administrative costs but such a millenium is probably politically unattainable. Since this care can be best given on the local level, the only solution at present seems to be a distribution of state funds to counties by a plan based partially upon actual need—somewhat similar to the fund used for educational purposes. The procurement of such funds which may be from additional taxation or a diversion from present state income is a problem for the legislature to solve.

There has been some criticism when funds were available in the past that it was unfair to pay the landlord, the grocer, the hospital and the druggist and expect the physician to donate his services. While this is probably true and may be corrected in time by a partial or percentage payment to physicians at least in rural areas, we can waive such consideration for the present provided other costs of medical care are made available to those unfortunates who cannot help themselves. Let us remember that excerpt from Robert Louis Stevenson's dedication to the physician ".....Generosity he has, such as is possible to those who practice an art, never to those who drive a trade....." Without countenancing the ingratitude of those who can pay and won't, we can well afford to offer our services cheerfully to those who would pay but can't. Such has been our practice for generations. If it is necessary to continue this policy indefinitely in order to solve the problem of medical care to the indigents—the profession can be counted upon to make the sacrifice.

Control of the Chronic Illnesses

A sequel to the problem of the medical indigent is the control of chronic illnesses. A chronic illness because of its duration, expense and cessation of earning power, may make one who is well-to-do become an indigent in time. With the control of many acute diseases accomplished, chronic illnesses are certain to increase in number. Already some of our neighboring states are recognizing this problem but while certain unofficial groups are discussing it here in our state no workable plan has yet been offered.

Many chronic illnesses can be prevented by careful living, and education regarding such rules should be emphasized. Unfortunately, they cannot be enforced effectively as can immunity measures in the control of communicable disease.

While many sufferers of chronic illnesses require only domiciliary care, others require the minimum treatment offered by nursing homes. Some can be rehabilitated by active hospital study and care. Such institutions for the latter group should be in affiliation with a medical center where proper diagnosis and screening could be done. We have no such institutions per se in Kentucky.

A careful study of those with chronic illnesses will show that many patients can be salvaged and become at least, partially self-supporting and comfortable.

It is a great tribute to American generosity that so much of the funds for research, education and actual treatment are made possible by voluntary fund raising. It is appalling to think what would happen to the cancer, heart, arthritis, infantile paralysis, cerebral palsy, alcoholism, tuberculosis, and blind programs if such private support were withdrawn. This will probably never happen because of the inherent kindness of the average person who considers such contributions a privilege.

The state has partially realized its obligations and is making limited contributions to some of these projects. There is need, however, of a definite plan for statewide discussion and organization as well as increased financial assistance.

Geriatrics

Actively associated with medical indigency and chronic illness is the subject of geriatrics. The aging population is a creature of our own efficiency. As time goes on there will be more and older people in this category. Pediatric surgery is more than just a matter of using small instruments. Geriatrics medicine requires more than milder narcotics and stronger laxatives. Continuing advances have made all types of surgery available to the elderly group. Their psychology must be understood. The care of the aged is a real challenge to our adaptability. The growing importance of the subject is such that we must prepare now to be able to take care of this problem as it arises. A committee has been appointed for this purpose by our own organization.

Extension of Voluntary Health and Hospital Insurance

The widest possible extension of voluntary health and hospital insurance is the most effective measure to provide ade-

quate medical care and remove the threat of expensive, inefficient and ineffectual compulsory health insurance. The growth of such voluntary plans is one of the most amazing developments in actuarial history. It is our unquestioned responsibility to encourage our patients to secure these contracts. The goal should be practically complete coverage of all except the indigent, and even they might be included under group policies purchased by the various local communities if and when such becomes actuarially feasible.

There has been some objection to health insurance plans that include an allowance for medical service on the grounds that the fees paid are usually a little less than those of the prevailing schedule. This will, of course, vary in different communities. However, even if this be true and the regular fee schedule as a result be lowered, most of us will fare better by a higher percentage of collections. And, if this were not so, we should still support such insurance as a public good because of the security it offers to the average person. Many feel that we should go further and accept the fee as full payment for service rather than a partial cash indemnity. With broader coverage and resulting lower cost, there might be a sufficient increase in fees possible to make this acceptable to all.

In addition to the usual standard policies, there should be one for catastrophic illness. Some commercial companies are already exploring this possibility. A policy of this kind could take over where the conventional contracts terminate or, in order to get the cost still lower, could indemnify only after a stated minimum of time or money expenditure has been incurred, resembling in a way the "deductible clause" in automobile collision insurance.

While supporting the voluntary nonprofit mutual plans under our own auspices, we should be fair and acknowledge to ourselves and to our patients that insurance underwriting is also a legitimate profit-making business and that most of the commercial firms are entirely reputable, fair in their settlements and deserve our support. We owe it to our patients to familiarize ourselves with the status of the various companies. Knowing that we have such information available may result in more liberal treatment by the few unfair companies. It is encouraging to be able to report that our own insurance committee is attempting to develop an educational program that will enable the public to select good insurance policies. Our insistence in all cases must be upon the principle of a free choice of physicians on a fee for service basis.

Accident Control

Accident control includes both accident prevention and the treatment of victims of trauma. We have worked hard to teach first-aid methods to thousands of people. One of our groups is very properly concentrating upon ambulance drivers. However, adequate treatment of the living and proper identification and burial of the dead are most ineffective in controlling the economic and social losses due to accidents. Management and labor have shown that most industrial accidents are avoidable. The same is true of the terrific traffic accident toll. We have two clearly defined responsibilities. One is unequivocable support of traffic regulations. The other is leadership in a campaign to persuade automobile manufacturers that they have a moral obligation to build safety into their cars—not by crash helmets, safety belts, and padded dashboards but by less speed, better brakes, and sturdier construction. The present uncontrolled competition for higher speeds and greater horsepower must be discouraged in some way. As long as prospective drivers are tested only for physical ability and knowledge of traffic laws, too much will not be accomplished. Some control must be built into the new car to compensate for the tempermental instability evidenced by many drivers. This factor is responsible for many accidents, is difficult to evaluate by present tests, and is impossible to penalize under current regulations. As physicians, we have not only a special interest but also a special responsibility in this entire field.

Medical Care of Veterans

It is to be regretted that the medical care of veterans has to be one of our unsolved problems. There are far too many misunderstandings in regard to this subject. The official position of our profession is first, that all service connected disabilites, surgical or medical, are the responsibility of the government. Secondly, psychiatric disorders and tuberculosis even if non-service connected are considered eligible to receive the same care as though service connected until local facilities are adequate to assume their legitimate obligations to treat such cases.

Morally every man has the obligation to defend his country. When he voluntarily exercises this privilege or when he is compelled to do so, he is discharging a debt and not building up an asset that should entitle him to preferential treatment for life. He should be glad that he came back whole and that he had such a favored country to return to. He, too, should feel an obligation to the man who returned disabled. The best way to care for the man disabled in service is to concentrate our efforts upon him. With the growing number of veterans it will in time become a fiscal impossibility to care for all. Making our limited facilities available to those whose disability is unrelated to service will decrease the care that can be given to those really entitled to it. This growing octopus of medical care for all veterans could overnight revolutionize our way of life and unstabilize our economic structure if Congress were to add only one phrase "and their dependents" to the present legislative acts, regarding medical care to veterans.

Most of us are veterans and we have no quarrels with veterans but the public looks to us for leadership in explaining this problem. We must accept that responsibility and show the inevitable results of selfishly drawn legislation. The average veteran is a reasonable man or woman, he realizes that his best personal security is the security of the country as a whole. It is difficult to believe that the majority of them support some of their leaders in the present propaganda for unlimited medical care to all veterans. We must work with other groups to solve this problem which confronts us and generations to come.

Public Non-Professional Activities

Many, or most, physicians would prefer to practice medicine within the sheltered confines of their profession. However, times have changed and this is no longer possible. We are expected to pursue many public non-professional activities and must do so whether we like it or not. To keep abreast of our unsolved problems, we must ally ourselves with many various groups. It is our obligation to seek and merit their support. In either official or advisory capacity, our services are needed by school authorities and health boards. Luncheon or service clubs depend upon us for information and suggestions in health matters. We can be of real service in the legislature and in other selective and appointive positions. Proper political connections which have been foreign to us in the past are essential since health legislation is in the hands of politicians. Sincere church affiliation not only makes our experience useful in many complex situations but also is exemplary to others and consoling to ourselves.

We must cooperate with the press in furnishing the public accurate information on health matters. This is a responsibility we must accept.

In addition to these non-professional or, at most, quasi-professional activities there are some that are strictly non-professional. Fund raising drives must be supported, cultural projects encouraged, and problems such as juvenile delinquency combatted.

To do these things requires more sacrifice of time and energy on the part of the physician than it does of many others. However, it is both necessary and worthwhile. The problem of the proper extent of our public activities may not be completely solved at present. Until it is, we may well bear in mind that for the survival of our present form of government and our personal way of life, there is no substitute for service.

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EDITORIALS

NOVEMBER 14-20, "NATIONAL DIABETES WEEK," A SERVICE OPPORTUNITY

Since the beginning of the Kentucky State Medical Association's annual Diabetes Detection Drives in 1951, the lay public has shown, in many ways, that it deeply appreciates the interest of the medical profession through this means to eliminate suffering and death from diabetes.

Few, if any, other activities of the medical profession have brought home so clearly to the public that the primary purpose of medical organizations is better health for the patient. While some may understand how medical meetings and other professional group activities rebound to their benefit, activities such as the Diabetes Detection Drive, directed nationally, locally and across the state by physicians, bring home the message of organized service in terms that all can comprehend.

Physicians of Kentucky have reason to be proud of the way in which they have cooperated with the KSMA Diabetes Committee and the American Diabetes Association in almost every county of the commonwealth. The record speaks for itself, with well over 500 persons discovered who had not known they had diabetes.

If the doctors needed further evidence of the desire of the public for this fine service, they should have found it in the fact that almost 1500 persons availed themselves of the free blood test for diabetes which was offered at the association's state fair booth. As a by-product, countless additional thousands of persons were made aware that Kentucky's medical profession aims to serve them both as individual patients and a collective public.

This year the drive will be held during the week of November 14 to 20. Physicians all over the nation will be giving free urine sugar tests during that week. Nowhere, however, from all reports, will they be doing a finer job than in Kentucky.

The greatest difficulty in evaluating such an effort comes through the follow-up on the positive urine sugars that are found. Both the fact and the method of such follow-ups is important if we are really to do the best possible job in this public service effort. For those who have not read the Special Article by John S. Llewellyn, M.D., in the October Journal, it is recommended that they do so. It contains a wealth of valuable information on this point.

CARLISLE MORSE, M.D.
Louisville, Chairman
KSMA Diabetes Committee

SHOULD MEDICINE ADOPT FIXED FEE SCHEDULES?

Whatever may be the merits or demerits of his position, Edward J. McCormick, M.D., immediate past-president of the AMA, started a lot of serious discussion both within and without the medical profession when he came out in his President's Address for average fee schedules. This is evident from what has been said by representatives of both the public and the profession during the months that have intervened.

Dr. McCormick, in recommending that regional average fee schedules be established with local medical societies calling to account those doctors who made charges over and above "the reasonable fees determined," may or may not be right. He has, however, done a service by focusing attention of the profession on an important aspect of its relations with the public. Quite possibly the most important aspect.

"I have felt for years," Dr. McCormick said to the AMA House of Delegates, "that there has been as much concern over the uncertainty of a fee for professional services as over the actual fee itself."

The *San Francisco Chronicle*, commenting editorially on Dr. McCormick's address, said, "This is a frank diagnosis of what is certainly one of the medical profession's biggest public relations problems—the sliding fee.

"In the Bay Area, we've had experience with the establishment of medical fees. Contra Costa County doctors voluntarily adopted a plan last September under which they are ethically bound to charge no more than the "usual fee" for the area without first obtaining the agreement of the patient. Five other California county medical societies are about to try it.

"The Contra Costa plan has a leeway which Dr. McCormick's average fee plan lacks, it recognizes the right to fix a higher-than-usual fee with the understanding of the patient. As professionals with varying individual skills, doctors should not be forced to give up this right. For example, a patient who, because of his wealth, temperament, or the extreme difficulty of his care, expects more than usual attention from a doctor should expect a more than usual fee. He would be told to expect it under the Contra Costa plan, but under the average fee schedule, as we understand it, no patient would be subject to extra charge.

"The distinction is important; it grows out of the free enterprise principle governing contracts for professional services. Doctors are human; left free to charge for it, they will be more likely to give extra service in cases where it is appropriate and agreed upon. This is something for the public, as well as the doctors, to have in mind in judging the controversy."

The *Chronicle's* restraint and balance in its editorial comment about Dr. McCormick's address only serves to underscore its calm implication that something must be done to resolve the public's uncertainty about medical fees. This, of course, was the essence of Dr. McCormick's plea whether the specific solution is right or not.

The serious efforts made by the AMA in the past to encourage physicians to discuss fees with the patient and the wide use by physicians everywhere of the AMA plaque inviting patients to feel free to discuss fees indicates professional recognition of how important the matter of fees has become.

The tremendous growth of voluntary health insurance has further emphasized the problem. The medical profession has been deeply concerned about seeing that the insurance which people buy really affords them some protection. This concern has been right and proper. At the same time, however, it must be recognized that many difficulties have been placed in the way of the insurance industry through its inability to know what professional charges for given procedures will be.

Whatever will be finally worked out, it is clear that the problem is a devilish one and that real ingenuity will be required to solve it to the satisfaction of all. As the *San Francisco Chronicle* points out, the freedom of the physician is an important consideration in fees as well as in other matters.

It may be that the experiments now going on in Contra Costa County and other California counties may show the way. Perhaps some other approach may be satisfactory. In any event, however, it behooves every physician to be giving serious consideration to proper handling of the fee problem.

Manuscript Memos

Mauuscripts should be submitted in duplicate to the Journal of KSMA, an original copy and one carbon, and typed with double spacing. Maximun length of an article should not exceed 4500 words, and the Board of Consultants on Scientific Articles prefers that they be briefer than this when possible.

Footnotes and bibliographies should conform to the style of the Quarterly Cumulative Index Medicus published by the American Medical Association. This requires in the order given: name of author, title of article, name of periodical, with volume, page, month—dav of month if weekly—and year. The Journal of the KSMA does not assume responsibility for the accuracy of references used with scientific articles.

All scientific material appearing in the Journal is reviewed by the Board of Consultants on Scientific Articles. If illustrations are submitted with a paper, the Journal will assume the cost for the first three one-column width half tones. The cost of additional illustrations will be borne by the essayist.

Arrangements for repriuts of an article should be made directly with the publisher of the Journal, Mr. J. G. Denhardt, Times-Journal Publishing Company, Bowling Green, Kentucky.

Please mail your scientific articles to the Journal of the Kentucky State Medical Association, 620 South Third Street, Louisville 2, Kentucky.

President's Page

In view of the continued evolution of prepaid medical care plans and the popularization of group care programs, it is imperative that we not lose sight of certain basic medical freedoms.

These are:

1. The freedom to charge on a fee for service basis.
2. The freedom to practice medicine as we individually believe proper.
3. The freedom to teach ourselves and others.
4. The freedom to do and direct medical research.
5. The freedom of choice of physician by the patient.

It is our duty to maintain these freedoms and we cannot tolerate any force which tends to destroy them regardless of its origin.

The obligation of their maintenance is to be considered a privilege and we cannot hope to perpetuate them unless we continue a high standard of ethical conduct. We should charge adequate but not exorbitant fees, teach only truth to ourselves and others, take more interest in medical research and take more interest in young doctors and medical students, never putting a patient or another doctor in a position from which we ourselves would normally recoil.

We cherish these freedoms. We are convinced they are true. We know they did not happen by accident. We must accept our responsibilities in their preservation and so discipline ourselves in practice that these freedoms cannot be threatened.

C. C. Sparks

PRESIDENT

ORGANIZATION SECTION

KSMA House Chooses Dr. Gaither New President-Elect

Gant Gaither, M.D., Hopkinsville, who has been active in the affairs of the Kentucky State Medical Association since 1912, was chosen President-Elect at the closing session of the House of Delegates, Wednesday, September 22.



Dr. Gaither

He will take office as president at the conclusion of the 1955 meeting. Dr. Gaither has done a far-flung scope of surgery in Western Kentucky and is actively associated with a number of hospitals. For the past 15 years he has served as President of the Board of Trustees at Jennie Stuart Memorial Hospital, Hopkinsville.

In August, 1954, Dr. Gaither appeared on Edward R. Murrow's program, "This I Believe." He has been practicing in Hopkinsville since 1912 except for the years during World War I when he volunteered his services with the United States Army. In 1924, Dr. Gaither became a Fellow of the American College of Surgeons at a meeting in New York City, under the presidency of Charles Mayo, M.D.

Chosen as Vice Presidents of the KSMA were:

Coleman C. Johnston, M. D., Lexington, (Eastern)

Arthur T. Hurst, M.D., Louisville, (Central)

Jesse T. Funk, M.D., Bowling Green, (Western)

Maximum Participation Urged for Diabetes Drive, Nov. 14-20

November 14-20 are the dates for the 1954 annual Diabetes Detection Drive, sponsored by the Kentucky State Medical Association in cooperation with the American Diabetes Association. During this week every KSMA member has been asked by the Diabetes Committee, under the chairmanship of Carlisle Morse, M.D., Louisville, to give free urine sugar tests to all persons requesting them.

Responses from the county medical societies indicate this year will see a maximum participation all over the state in the campaign to discover previously unknown diabetes cases, according to Dr. Morse.

"The continued success of this annual public service by Kentucky's medical profession is dependent primarily upon the job done by the county medical society diabetes committees and the individual physicians across the state," Dr. Morse said.

"Through their efforts in previous years, the KSMA has received national recognition in diabetes detection work. From the interest shown this year by the county societies, it looks as if the profession intends to keep its interest in the Diabetes Detection Drive at a high level. This is absolutely necessary," he said, "if we are to keep pace with the growing recognition by the public of the campaign's importance."

As in the past, free testing materials are made available to participating physicians through their county diabetes chairmen. Publicity aids have been distributed by both the American Diabetes Association and the KSMA.

The annual Diabetes Detection Drive is unique among such types of activity in that it involves no fund raising on national, state or local level. It is also distinguished by the fact that all activities of the American Diabetes Association are under the direction of physicians.

House Presents Two Awards to Doctors Jackson, Wallin

The KSMA House of Delegates selected Elbert W. Jackson, M.D., Paducah, as the recipient of the Distinguished Service Award and William Bridges Wallin, M.D., Brooksville, as the Outstanding General Practitioner of the Year, during the first session of the House, Monday, September 20, in Louisville.

Bruce Underwood, M.D., Louisville, secretary and general manager of the KSMA, presented the association's top awards on Thursday, September 23, preceding the Inaugural Ceremony at the Columbia Auditorium.

Dr. Jackson, who is currently Vice-Speaker of the House of Delegates, it was pointed out, has rendered years of valuable service to organized medicine in Kentucky. In 1946, he held the office of President of the KSMA, and served as the association's Vice-President on two separate occasions.

Dr. Wallin, who has practiced for 61 years in Brooksville, has served as Vice-President of



William Bridges Wallin, M.D., Brooksville, is presented the KSMA Outstanding General Practitioner of the Year Award by Bruce Underwood, M.D., Louisville, secretary and general manager, September 23, during the Anual Meeting in Louisville.

the Kentucky State Medical Association and the Bracken County Medical Society, and is active in civic affairs of his community.

In addition, Dr. Jackson served as President of the Kentucky Surgical Society in 1953 and held highest office in his local county and district medical societies. He has been a member of the McCracken County Board of Health for 16 years.

After graduating from the University of Louisville School of Medicine in 1912, Dr. Jackson took hospital training in Louisville and established practice in Paducah in 1914. He has practiced there continuously except for the period when he served in World War I as a captain.

The Journal regrets that the photograph of the presentation of the Distinguished Service Award by Dr. Underwood to Dr. Jackson was a failure.

Dr. Wallin has kept pace with the advances of medicine since his graduation from the University of Louisville School of Medicine in 1893 by taking post-graduate refresher courses from time to time. Through the years, he has delivered more than 4,000 babies.

Selection by the KSMA as its Outstanding General Practitioner award winner, makes Dr. Wallin eligible to compete for the American Medical Association's 1954 GP Award of the Year, which will be made at the annual clinical session in Miami, Florida, November 29. J. I. Greenwell, M.D., New Haven, who won the KSMA award in 1953, also won the AMA award to become the first Kentucky physician to receive this honor.

Record Breaking Attendance, 1,938 Present at 1954 Session

A total of 1,222 physicians attended the 1954 Annual Meeting of the KSMA, breaking the all-time record of 1,085 set at the Centennial Meeting in 1951. A total of 1,938 registered at the Columbia Auditorium in all classifications, shattering the Centennial attendance record of 1,911.

This figure does not include the 185 members of the Woman's Auxiliary to the Kentucky State Medical Association, who registered at their annual session which was held in the Brown Hotel, Louisville.

Scientific essayists, both state and national, expressed pleasure with the excellent attendance at both the morning and afternoon sessions during the three day meeting. Experienced observers said the attendance at the scientific sessions was far above the average.

Exhibitors were pleased with the great amount of interest on the part of association members in the products and displays of the commercial exhibits, according to the Liaison Committee of the Medical Exhibitors Association covering the KSMA Annual Meeting

Registration figures by classification are as follows:

Members	924
Guest Physicians	150
Guests	166
Exhibitors	174
Interns-Residents	148
Registered Nurses	25
Medical Students	284
Technicians and Office Assistants	67
	1,938

County Society Officers to Meet April 7, 1955, Lexington

Thursday, April 7, 1955, is the date which has been set for the Fifth Annual County Society Officers Conference, to be held at the Phoenix Hotel, Lexington, according to Clyde C. Sparks, M.D., Ashland, KSMA president.

Plans are underway to obtain speakers who are specialists in their respective fields of organized medicine to participate on the day-long program. Subjects to be discussed at the 1955 conference were selected by County officers and Committeemen attending the 1954 session, who were asked to indicate on a special questionnaire topics they felt would be most profitable and interesting to the majority.

Dr. Baughman to Head Council; Four Councilors Re-elected

Branham B. Baughman, M.D., Frankfort, councilor from the Seventh District, was elected Chairman of the Council at the annual re-organization meeting, Thursday, September 23, in Louisville.



Dr. Baughman

Dr. Baughman, who has served as a member of the Council for the past five years, will automatically be Chairman of the Executive Committee of the Council. He succeeds J. Farra Van Meter, M.D., Lexington, as Chairman.

At present Dr. Baughman is Chairman of the KSMA Legislative Committee and Treasurer of the Kentucky Physicians Mutual Board of Directors. He is a past president of the Board. In addition, Dr. Baughman is a member of the American College of Surgeons, the Southeastern Surgical Congress and the American Medical Association.

Richard R. Slucher, M.D., Buechel, councilor from the Fifth District, was elected to serve as Vice-Chairman of the Council and the Executive Committee. Dr. Slucher, who completed a three-year term of office as a member of the Council, was re-elected to serve a second term until 1957. Bruce Underwood, M.D., Louisville, was re-elected general manager.

Charles B. Stacy, M.D., Pineville, Fifteenth District, was elected to succeed Edward Wilson, M.D., Pineville, at the final session of the House.

In addition to Dr. Slucher, three other councilors whose terms expired in 1954, were re-elected. They are: L. O. Toomey, M.D., Bowling Green, Sixth District; Edward B. Mersch, M.D., Covington, Eighth District; Hugh Mahaffey, M.D., Richmond, Eleventh District.

Annual Meeting Speakers Appear On 20 Radio-TV Programs

Radio and television coverage of the KSMA Annual Meeting, September 21-23, included 20 special programs, which featured association members and guest scientific speakers, totaled more than seven hours of broadcasting time.

The most complete coverage of any Annual Meeting was effected by Louisville radio stations WHAS, WKLO, WGRC, WINN and WAVE which devoted five broadcasting hours to KSMA programs and WAVE-TV and WHAS-TV, which contributed two hours of television time.

In addition, "The First Annual Radio Report on the KSMA Meeting," a half-hour transcription, was prepared by WAVE and broadcast on a network of eight stations blanketing the state.

Stations included in this group were:WKYB, Paducah; WVJS, Owensboro; WKCT, Bowling Green; WVLK, Lexington; WPKE, Pikeville; WZIP, Covington; WCMI, Ashland; and WCPT, Corbin.

Gov. Lauds Profession's Efforts With Public, Legislators

Since the medical profession in Kentucky decided to do something about its relations with the public it has had a far greater influence for good in the legislation and elsewhere, Governor Lawrence W. Wetherby told those who attended the Annual President's Luncheon, Tuesday, September 22, at the Brown Hotel, Louisville.

The Governor urged the physicians to continue to work with the legislators in an effort to pass legislation improving the health of the public.

"I know of no group that can have a greater influence on public opinion and on legislation than the doctors. Let's move together to build a greater Kentucky," he said.

Governor Wetherby recounted a number of legislative highlights of medical interest since 1948:

(1) Establishment of the Medical Research Commission in 1948. The commission receives



Governor Lawrence Wetherby compliments KSMA physicians at the President's Luncheon for their achievement in securing better health for the citizens of the Commonwealth in his address, "Medical Progress in Kentucky."

$300,000 a year to pay for research at the University of Louisville School of Medicine.

(2) Passage of a hospital-licensure act in 1952 to insure better and more sanitary hospitals for the people of Kentucky.

(3) Establishment of the Department of Mental Health in 1952.

(4) Revision of laws regarding commitment of patients to mental hospitals in 1954.

(5) Complete revision and modernizing of the medical practice act. This is the first time such an undertaking has occurred in the last 50 years.

(6) Quarantine, made compulsory this year, of persons infecting others with tuberculosis.

KSMA Delegates Handle Heavy Agenda at Annual Session

A heavy agenda, good attendance and lively interest characterized the 1954 sessions of the House of Delegates at the Annual Meeting at the Columbia Auditorium. According to Speaker Charles A. Vance, M.D., of Lexington, 146 delegates registered for the two sessions, which is an unusually good attendance.

The first session was held Monday evening, September 20. At this meeting, the House voted to elect the 1954 winners of the Distinguished Service Award and the Outstanding General Practitioner Award. The House also received reports from the 50-odd committees of the association, and, in addition, those of the officers.

Delegates were highly complimentary at many of the committee reports which revealed the substantial progress the association is making on a wide variety of fronts, Dr. Vance said.

Among the more important recommendations accepted by the House was the proposal of the Council that the House of Delegates be opened to the Press and that executive sessions of the House be held only on special call. The House has been meeting in executive session exclusively since 1952.

The House voted unanimously to accept retiring President J. Duffy Hancock's recommendation that the association appoint a Labor Management Committee and to seek to improve relationships between the medical profession and the various labor groups.

The House voted to accept the recommendation of the KSMA Education Campaign Committee to pledge its membership to the principle of no person being denied medical care because of his inability to pay and commended the Advisory Committee on Pediatrics in its efforts to establish a "Child Accident Prevention Week" during May of 1955.

The recommendation of the Fayette County Medical Society to correct the by-laws, Chapter 9, Section 1, relative to the annual dues was accepted. The 1953 House had overlooked making this specific change in the by-laws when an increase in the dues was voted.

In accepting the report of the Committee on Nurse Training, the House voted to encourage each member to support nurse recruitment programs, recommended that the facilities of the Postgraduate Medical Education Bureau set up by the Committee on Medical Education be used more fully by the membership, and highly commended the Woman's Auxiliary and the excellent work it did during the past year.

A complete summary and digest of the meetings of the 1954 session will be carried in the December issue of the Journal of the KSMA.

Dr. Hancock Gives Breakfast

One of the highpoints of the Annual Meeting for the official family of the association was a breakfast given for the officers and councilors by the retiring president, J. Duffy Hancock, M.D., Louisville at the Brown Hotel. There was no formal program, but the retiring president did express his appreciation for the cooperation and support the officials had given his administration.



President J. Duffy Hancock, M.D., Louisville, introduces distinguished guests at the two Speakers Tables during the President's Luncheon, Brown Hotel Roof Garden, September 22.



Representing the incoming, present and retiring KSMA chiefs, J. Gant Gaither, M.D., Hopkinsville, president-elect; Clyde C. Sparks, M.D., Ashland, 1954-55 president, and J. Duffy Hancock, M.D., Louisville, 1953-54 president, join ranks for an official KSMA family chat at the reorganization meeting of the Council, September 23, 1954.



One of the highlights of the President's Luncheon, September 22, during the Annual Session was the introduction of past presidents. Seated, from left to right, C C. Howard, M.D., 1834; E. M. Howard, M.D., 1942; O. O. Miller, M.D., 1944; J. W. Stovall, M.D., 1945; E. W. Jackson, M.D., 1946; John Scott, M.D., 1939; standing, H. H. Houston, M.D., 1949; Clark Bailey, M.D., 1952; G. Y. Graves, M.D., 1953; C. A. Vance, M.D., 1948; and Guy Aud, M.D., 1947.

Golf Winners Listed in Largest KSMA Tournament

A total of 49 members registered to play golf in the 1954 Annual KSMA Golf Tournament which was, according to veteran observers, the largest number ever to play in this event. Clifton G. Follis, M.D., Glasgow, said his committee was well pleased with the tournament.

He added that for the first time two traveling cup trophies would be presented. A third trophy will be added at the 1955 tournament, Dr. Follis said, which will be known as the Senior's Low Gross Trophy. He stated that a very fine group of prizes was given this year and that the KSMA Golf Association was left with a reserve that would guarantee the giving of more substantial trophies next year.

John A. Hemmer, M.D., Louisville, had the low overall net score of 73. Dr. Hemmer has won possession of the low net trophy for this year. Kenton D. Leatherman, M.D., Louisville, shot an 84 to take the low gross overall honors. Dr. Leatherman also won the right to keep the low gross cup for the first year.

Tuesday, low gross honors went to Richard G. Burman, M.D., Louisville, and low net honors to Robert J. Hoffman, M.D., South Fort Mitchell. On Wednesday, the low gross score of the day was made by T. J. Overstreet, M.D., Lexington, while Henry Asman, M.D., Louisville, made the lowest net score.

M. J. Reardon, M.D., Covington, stroked the lowest gross as Claud W. Chappell, M.D., Louisville, came in with the low net score on Thursday.

Mental Health Group Meets

Nicholas P. Dallis, M.D., Toledo, was the featured speaker at the fall dinner meeting of the Kentucky Association for Mental Health, held at the Phoenix Hotel, Lexington, October 13, according to Frank A. Yost, Hopkinsville, president. Dr. Dallis, creator of the illustrated feature, "Rex Morgan, M.D.," was one of the principal speakers at the KSMA President's Luncheon, Wednesday, September 22.

Student Delegate Injured

Tom Heavern, Ft. Thomas, student AMA delegate from the University of Louisville chapter, was seriously injured in an automobile accident, Sunday, October 3, 1954, near Union, Kentucky. Mr. Heavern is in his junior year and represented his chapter at the Annual Meeting of the KSMA in September.



"First Ladies" of the Woman's Auxiliary get together before the annual style show, Wednesday, September 22, during the Annual Session of the Woman's Auxiliary to the KSMA. Reading from the left, Mrs. Ward Bushart, Fulton, KSMA Woman's Auxiliary president-elect; Mrs. Karl Winter, Louisville, 1954-55 president and Mrs. Clyde C. Sparks, Ashland, 1953-54 president. Honor guest of the 1954 meeting was Mrs. Mason G. Lawson, Little Rock, Arkansas, president-elect, Woman's Auxiliary to the Southern Medical Association.



Distinguished illustrated feature writer, Nicholas P. Dallis, M.D., Toledo, introduces his creation, "Rex Morgan, M.D.," along with his assistants, Mr. Marvin Bradley, who draws the characters in the strip, and Mr. Frank Edgington, who supplies the artistic background. Dr. Dallis and his artists appeared at the President's Luncheon, Brown Hotel Roof Garden, September 22.

Council Names 1954-55 Committees During Annual Meeting

Standing Committees of the Council for the 1954-55 year were elected at the annual reorganization meeting of the Council, Thursday, September 23, during the last day of the Annual Meeting in Louisville.

According to B. B. Baughman, M.D., Frankfort, new chairman of the Council, committee appointments are being announced at an early date as possible in order that work of the committees may continue without interruption.

Personnel of the Committees is as follows:

Committee on Medical Service

G. L. Simpson, Greenville, Chairman, (term expires 1957)
Walter Cawood, Harlan, (term expires 1956)
John Haynes, Madisonville, (term expires 1956)
Cy Waldrop, Williamstown, (term expires 1955)
Robertson Joplin, Louisville, (term expires 1957)

Public Relations Committee

Glenn Bryant, Louisville, Chairman, (term expires 1955)
David Cox, Louisville, (term expires 1956)
William Pennington, Lexington, (term expires 1956)
Robert Hoffman, S. Fort Mitchell, (term expires 1955)
Edward. Wilson, Jr., Pineville, (term expires 1957)

Education Campaign Committee

W. Vinson Pierce, Covington, Chairman
George P. Brockman, Greenville
Richard G. Elliott, Jr., Lexington
Wendell V. Lyon, Ashland
George W. Pedigo, Louisville
Mitchell Denham, Maysville
Charles B. Stacy, Pineville

Legislative Committee

B. B. Baughman, Frankfort, Chairman
Thomas V. Gudex, Louisville, Co-Chairman
Norman Adair, Covington
Rufus Alley, Lexington
Guy Aud, Louisville
Clark Bailey, Harlan
Daniel Bower, Barbourville
William H. Cartmell, Maysville
J. Gant Gaither, Hopkinsville
Orion Higdon, Paducah
C. C. Howard, Glasgow
E. W. Jackson, Paducah
Billy K. Keller, Louisville
Charles B. Stacy, Pineville
Charles B. Wathen, Owensboro

Medico Legal Committee

J. B. Lukins, Louisville, Chairman
Woodford B. Troutman, Louisville, Ex-Officio
Bruce Underwood, Louisville, Ex-Officio

Advisory Committee to the Editor

Guy Aud, Louisville, Chairman
James Hix, Owensboro
Richard J. Rust, Newport



Barry Bingham, president of the Louisville Courier-Journal and Times and WHAS Radio and Television, is introduced by J. Duffy Hancock, M.D., Louisville, KSMA president, to physicians and guests attending the Annual President's Luncheon, Roof Garden, Brown Hotel, September 22.

President's Luncheon Attended by Record-Setting 390

A record-setting-total of 390 physicians and their guests attended the Annual 1954 President's Luncheon, at the Brown Hotel, Wednesday, September 22, with J. Duffy Hancock, M.D., retiring president, presiding.

One of the featured speakers was Nicholas P. Dallis, M.D., Toledo, Ohio, creator of the illustrated feature, "Rex Morgan, M.D.," widely carried in 300 newspapers all over the world.

Dr. Dallis explained the background of the strip's development, in addition to reading a number of humorous letters he had received about "Rex Morgan, M.D.," whom he described as the best known physician in the world.

Mr. Marvin Bradley, who draws the comic strip characters, and Mr. Frank Edgington, who supplies the artistic background accompanied Dr. Dallis and gave a demonstration at the luncheon.

J. Farra Van Meter, M. D., Lexington, 1953-54 chairman of the Council, presented a special plaque to Barry Bingham, president of the Louisville **Courier-Journal and Times**, and WHAS TV and Radio, for a pioneering venture by WHAS-TV in telecasting a cancer operation last year.

New Committee Chairmen Meet During Annual Session

Approximately 45 KSMA Committee Chairmen and Officers for the 1954-55 year attended a special breakfast at the Brown Hotel, the last day of the Annual Meeting given in their honor by the incoming president, Clyde C. Sparks, M.D., Ashland.

Plans for the coming year were gone over and some of the more important issues the profession will face in Kentucky were discussed. The breakfast was the first meeting of this type held in recent years.

The excellent attendance and the interest shown were very encouraging, President Sparks said. He thanked the committee chairmen for accepting the many important posts and for agreeing to work in behalf of the profession and the people of the state during the coming year.

Dr. Taugher Heads Chest M.D.s

Lawrence Taugher, M.D., Louisville, was elected president of the Kentucky Chapter of the American College of Chest Physicians at the meeting of the group in Louisville, September 21, during the annual sessions of the KSMA.

Dr. Taugher succeeds John S. Harter, M.D., Louisville, as president. Other officers are J. Ray Bryant, M.D., Louisville, vice-president, and Alvin B. Mullen, M.D., Waverly Hills, who was re-elected secretary-treasurer. The Kentucky Chapter meets annually.



J. Farra Van Meter, M.D., Lexington, chairman of the Council, greets Mr. Barry Bingham, Louisville, as he comes forward at the President's Luncheon to accept a KSMA plaque presented to WHAS-TV, which pioneered in telecasting an educational cancer operation.



T. O. Meredith, M.D., Harrodsburg, president of Blue Shield of Kentucky, receives a plaque on behalf of the organization from Bruce Underwood, M.D., Louisville, secretary and general manager of the KSMA, during the Annual Meeting.

Blue Shield Honors Dr. Meredith

T. O. Meredith, M.D., Harrodsburg, president of Blue Shield of Kentucky, received a plaque on behalf of the organization for the five years of service he has given to the people of Kentucky.

The award, which was presented by Bruce Underwood, M.D., Louisville, secretary and general manager of the KSMA, during the Annual Meeting of the KSMA, September 23, was made by the National Blue Shield Commission. Blue Shield in Kentucky now numbers 251,000 members.

Ob-Gyn Residents Urged to Compete in Essay Contest

A prize of fifty dollars is being offered by the Kentucky Obstetrical and Gynecological Society to the resident in Kentucky who submits the most outstanding paper on obstetrics and gynecology before February 1, 1955.

According to Robert C. Bateman, M.D., Danville, secretary-treasurer of the society, the best three papers, as chosen by the Executive Committee of the Kentucky Ob-Gyn Society, will be presented by the author at the general meeting of the society at its annual spring meeting.

The members present at the meeting will choose the most outstanding of the three papers presented. All essays should be submitted to Dr. Bateman, 432 W. Main Street, Danville, Kentucky.

Southern Psychiatric Ass'n. Draws 212 to Louisville Session

A total of 212 physicians, including representation from 16 states, attended the Annual Meeting of the Southern Psychiatric Association, October 4-5, in Louisville, according to John D. Trawick, M.D., Louisville, 1953-54 president.

Joseph E. Barrett, M.D., of Richmond, Virginia, succeeds Dr. Trawick as president. Dexter M. Bullard, M.D., of Rockville, Maryland, was chosen president-elect of the association.

Governor Lawrence Wetherby addressed the group with a discussion of Kentucky's mental-health program and the state's part in training psychiatrists under the Southern Regional Education Board. He asked the association to support the organization of a mental-health research council for the South.

Service Requirements Announced For Non-Veteran Interns

October 10, 1955, is an important date in the Defense Department's program for staffing the military medical services after expiration of the Doctor Draft Act next July 1. By October 10, non-veteran interns are expected to have sent to the Pentagon their "Statements of Service Preference." On this form the interns will indicate 1-2-3 preferences among the services, whether they desire further deferment for residencies, and if so, the type of residency and first and second choice of hospitals.

The Department then will turn over the names to the three services for reserve commissioning, and decide by lot which interns will be defererd for residencies "in specialties essential to the military medical services." So far as practicable, the plan is to allow these non-veteran interns—who have a two-year service obligation under the regular draft—to go on active duty at a time convenient to them following the completion of their internship next spring. Already the Defense Department has enough information to know that about half the interns will request residency deferments—and that no more than half of these requests can be granted.

The program is known as "The Armed Forces Reserve Medical Officer Commissioning and Residency Consideration Program." It is jointly sponsored by Defense Department and the National Selective Service System. The latter will recommend that local boards defer men selected by Defense Department for residency training.

Editors Note: The above was taken from the **AMA Washington Letter**, No. 91, October 1, 1954.

AMA Clinical Session Meets In Miami, Nov. 29

Easier solution of medical problems that the family physician encounters is the general aim of the American Medical Association's clinical meeting in Miami, Florida, November 29 through December 2, 1954.

More than 100 physicians will present scientific papers or participate in panel discussions during the meeting, directed toward alleviating the everyday medical problems of the physician.

The meetings in Miami's Dinner Key Auditorium and the McAllister Hotel are expected to be attended by more than 3,000 physicians from throughout the nation.

Student AMA Elects President At 1st Fall Meeting

William P. Vonderhaar, Louisville, was elected president of the University of Louisville Student AMA Chapter at the first fall meeting, Monday, September 27.

Other officers elected were Ray Rose, Lexington, treasurer, and Lila Ann Hargon, Vine Grove, secretary. "Advantages of Medical Association" was the topic discussed by Jean Clos, executive secretary of the Jefferson County Medical Society, guest speaker.

"Our preliminary planning for future monthly meetings includes a schedule of diversified and interesting programs," Mr. Vonderhaar, the new president, said.

Special Telecast Seen by 325 At Annual Meeting

A high point of the 1954 Annual Session was the special closed circuit 24 cities telecast entitled "Management of Hypertension," sponsored by the American College of Physicians and Wyeth Laboratories. More than 325 physicians and their guests viewed the broadcast from a 11 x 14 foot screen at the Columbia Auditorium, September 23.

"The telecast was an experiment in the field of postgraduate medical education by the American College of Physicians and Wyeth Laboratories and we are indeed pleased that Louisville could be one of the 24 participating cities in this history-making effort," Sam A. Overstreet, M.D., Louisville, governor of the Kentucky Chapter of the College, said after the broadcast.

"The broadcast was very well attended, the comments on the manner in which the material was presented were universally good and we sincerely hope that it will be possible for us to share in any future broadcasts of this type," Dr. Overstreet stated.



This photograph shows a part of the special equipment and the audience viewing this epic-making closed circuit telecast that was presented the final afternoon of the Annual Meeting, September 23, 1954. (Courier-Journal photo)



The presidential oath of office is administered to Clyde C. Sparks, M.D., Ashland, by Council Chairman J. Farra Van Meter, M.D., Lexington, in the Columbia Auditorium where the Inaugural Ceremonies were held September 23.

Harlan Kiwanis Honors 5 M.D.s

Legion of Honor Certificates were recently awarded to five physicians of the Harlan Kiwanis Club for their service of many years standing, according to the **Kentucky-Tennessee Kiwanis Notes.**

Those honored are: Clark Bailey, M.D., 25 years; W. P. Cawood, M.D., 30 years; E. M. Howard, M.D., 30 years; J. B. Jones, M.D., 25 years; and W. R. Parks, M.D., 30 years.

Phone Messages Received During Annual Meeting Total 128

A total of 128 phone calls for physicians attending the KSMA Annual Meeting, were received and posted at the Columbia Auditorium, according to records in the Headquarters Office.

Telephone messages were handled through the combined efforts of the Jefferson County Medical Society's Physicians Exchange and the Kentucky State Medical Association's special message bureau.

This number of calls does not include messages received and delivered during the September 22, Wednesday afternoon session when the eight specialty groups met simultaneously.

Taylor County and Local Paper Sponsor Medical Forum

A highly successful public medical forum was held by the Taylor County Medical Society in Campbellsville, September 10, according to a report from W. Burr Atkinson, M.D., society president.

The forum, on the "Miracle of Childbirth," was sponsored jointly by the **News-Journal** of Campbellsville and the Taylor County Medical Society as the first in a series of four planned for this year. Other subjects will be cancer, heart, and the use and abuse of drugs.

"Between 250 and 300 persons attended the first meeting, despite keen competition from other public activities going on the same night," Dr. Atkinson said. "They asked many questions of the panel during the question period which followed brief talks by C. V. Hiestand, M.D., and William W. Shepherd, Jr., M.D.

"The cooperation of the **News-Journal** and other public spirited organizations combined to make the forum a success. In addition to excellent local publicity, the affair was written up extensively by the **Louisville Courier-Journal,** which sent Robert Clark, top reporter, and Warren Klosterman, photographer, to cover the forum.

"We cannot help but feel from our own experience," Dr. Atkinson continued, "that other medical societies can profit by sponsoring forums for their own communities. It furthers good relations of the profession with the community and both patients and doctors learn a lot."

All members of the Taylor County Medical Society serve on the question panel at the forums. In addition to Doctors Hiestand, Shepherd and Atkinson, they are R. D. Barton, M.D.; Henry F. Chambers, Jr., M.D.; Edwin L. Gowdy, M.D.; Lyman S. Hall, M.D.; M. M. Hall, M.D.; G. C. Lewis, M.D.; Wanless R. Mann, M.D., and Roy G. Wilson.

While medical forums designed to answer the lay public's questions on medical matters have been held in many parts of the nation, including Paducah, it is believed that the Taylor County effort was the first in which the newspaper co-sponsoring the forum was a weekly newspaper.

Dr. Atkinson urged that county societies which might be contemplating such public forums contact the KSMA Headquarters Office, which is ready to provide assistance for similar ventures elsewhere.

Dr. Massie Elected President Ky. College of Surgeons

Francis Massie, M. D., Lexington, was selected the new president of the Kentucky Chapter of the American College of Surgeons, at its meeting in Louisville, September 20. M. J. Henry, M.D., Louisville, is the out-going president.

J. Vernon Pace, M.D., Paducah, was elected vice-president, and Henry B. Asman, M. D., Louisville, was elected as the new councilor. James C. Drye, M.D., is serving a three year term as secretary-treasurer.

The Louisville meeting was the first scientific session for the Kentucky chapter which was formed a year ago. H. P. Saunders, M.D., Chicago, associate director of the American College of Surgeons, addressed a group of 125 chapter members and guests who attended. Dr. Saunders is a native of Hickman, Kentucky.

Ky. Receives Hill-Burton Funds

Kentucky has been allocated funds totaling $493,000 under the first year's operation of the Hill-Burton expansion act, passed by the last Congress to stimulate the construction of health facilities, according to a report from the AMA Washington Office. The sum of $146,000 has been earmarked for diagnostic-treatment centers in Kentucky and the same amount for chronic disease facilities. Rehabilitation facilities and nursing homes will each receive $101,000 under the act.

Post Graduate Program to be Presented

The Academy of General Practice and the University of Louisville School of Medicine will present the following program, Thursday, November 18, 1954, at the Lafayette Hotel, Lexington, Kentucky.

3:00 - 4:00	Recent Advances - Hematology—Dr. Everette Sanneman, Instructor in Medicine
4:00 - 5:00	Recent Advances - Pediatrics—Dr. Joseph Little, Associate Professor of Pediatrics
5:00 - 6:00	Recent Advances - Medicine—Dr. Walter S. Coe, Associate Professor of Medicine and Chief of Section on General Medicine
7:00 - 8:00	Dinner - Wives Invited
8:00	The Role of the American Academy of General Practice in American Medicine—Dr. Malcolm Phelps, National Director of American Academy of General Practice.



The above picture shows a typical crowd at the KSMA booth on diabetes which was a feature at the 1954 Kentucky State Fair. The exhibit included the first general public demonstration in Kentucky of the "Clinitron," an automatic blood-sugar testing machine. During the course of the fair, 1,382 persons received free blood-sugar tests at the booth. The usher in the left foreground was required at most of the time to keep the crowd from overflowing into and blocking adjacent booths. The exhibit was a joint project of the Education Campaign Committee and the Diabetes Committee. Members of the Jefferson County Woman's Auxiliary assisted in manning the Booth. The technicians were from the Laboratories of the Kentucky State Department of Health

Nominating Committee Elected

Five physicians were elected to serve on the Nominating Committee at the 1955 Annual Meeting of the KSMA, during the last session of the House of Delegates in Louisville, September 23, 1954.

Those elected to serve were: Charles M. Edelen, M.D., Louisville; Coleman C. Johnston, M.D., Lexington; Robert W. Robertson, M.D., Paducah; Richard Rust, M.D., Covington; and Charles B. Stacy, M.D., Pineville.

New Nursing Director Appointed

Mrs. Marjorie C. Tyler, Louisville, was appointed Executive Director of the Kentucky Board of Nursing Education and Nurse Registration and assumed her new post, September 1, 1954. Mrs. Tyler is a former member of the faculty of the Kentucky Baptist Hospital.

Mrs. Lois E. Streuter, Louisville, recently resigned as Executive Director following her marriage. For a brief time Mrs. Streuter will continue her association with the Board as consultant.

KSMA Receives 8 New Members

Eight physicians recently were added to the membership roster of the Kentucky State Medical Association. They are:

J. L. Becknell, M.D., Manchester;

B. F. Brown, M.D., Harrodsburg;

Henry F. Chambers, Jr., M.D., Campbellsville;

George M. Gumbert, Jr., M.D., Olive Hill;

William T. Rumage, Jr., Louisville;

Bernard J. Schoo, M.D., Louisville;

M. A. Shepherd, M.D., Harrodsburg;

Harold E. Shufflebarger, M.D., Grayson.

The Annual Christmas Seal Sale of the Kentucky Tuberculosis Association begins November 22, continuing through the month of December, according to E. R. Gernet, M.D., Louisville, president. He urges the medical profession of Kentucky to actively support this annual drive.

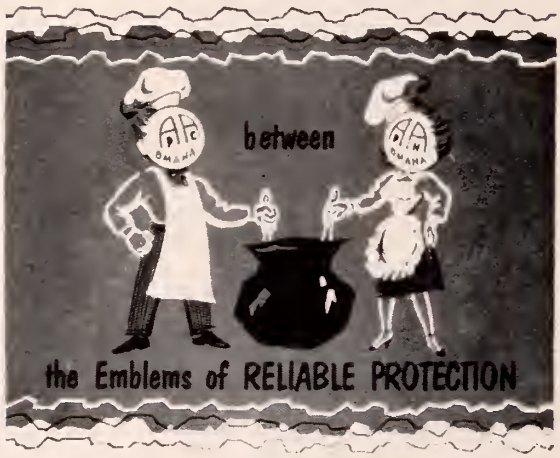
A new "Farm Accidents" exhibit has been prepared by the AMA for showings at local fairs, expositions and public gatherings. Emphasizing the comparative hazards of farming with other industries, this informative exhibit points up common farm accidents and ways of preventing them. More complete information may be obtained from the KSMA Headquarters Office.

BUYERS' GUIDE

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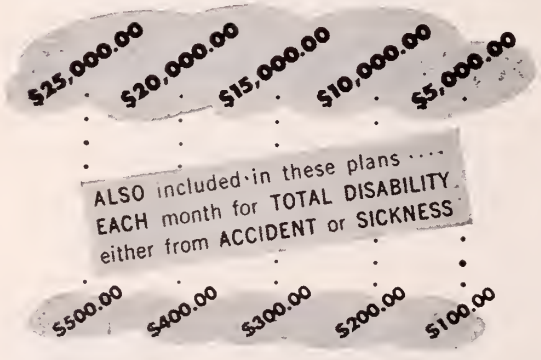
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News Items

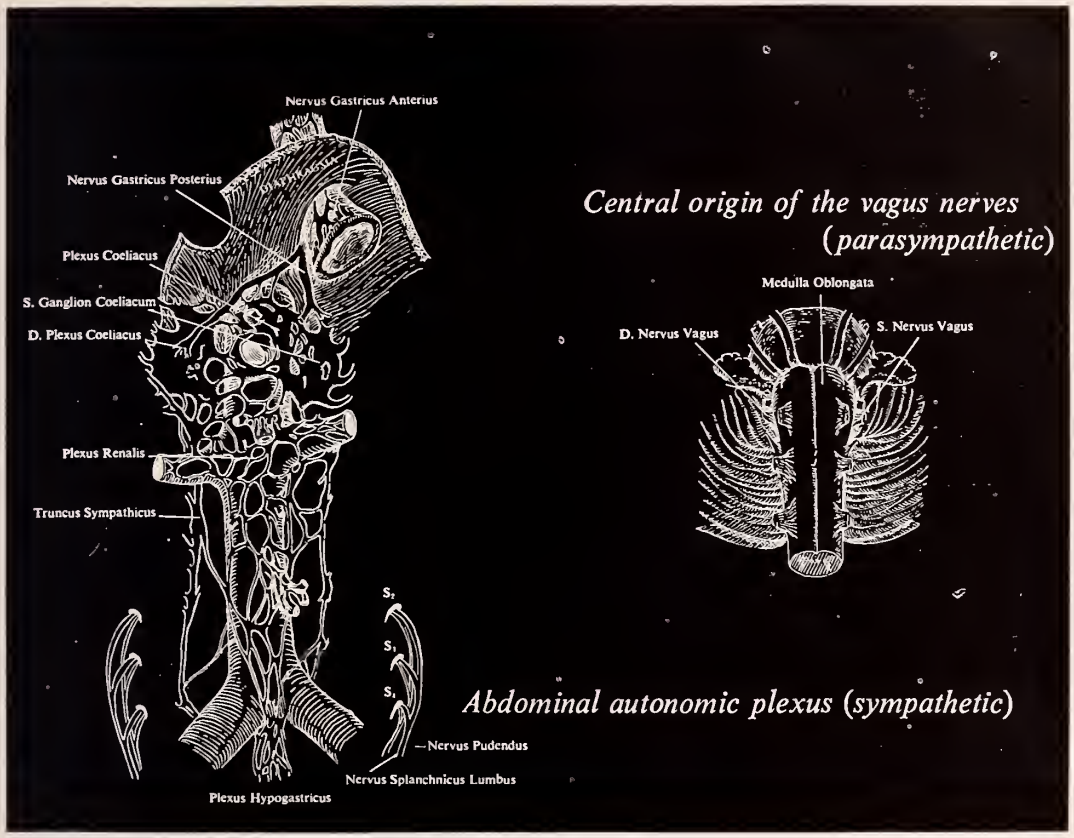
Richard E. Mardis, M.D., has announced the opening of his office in Louisville for the practice of internal medicine, including pulmonary diseases. Dr. Mardis was graduated from the University of Louisville School of Medicine in 1944 and interned at St. Joseph's Infirmary, Louisville. During 1948 and 1949, he took a residency in his specialty at Fitzsimons General Army Hospital, Denver, Colorado. From 1946 to 1953, Dr. Mardis served with the Army of the United States. Before locating in Louisville, he was Assistant Medical Director, District One, State Tuberculosis Hospital, Madisonville, from November 1953-August 1954.

Karl C. Kelty, M.D. has announced the opening of his office in Lexington for the practice of internal medicine. A native of Tennessee, Dr. Kelty was graduated from the University of Tennessee College of Medicine, Memphis, in 1943, and interned at John Gaston Hospital, Memphis. He was house physician at Riverside Hospital, Paducah, before taking a residency in internal medicine at the Veterans Administration Hospital, Louisville, from 1949-51. Dr. Kelty was a research fellow in clinical hematology at the University of Louisville School of Medicine from 1951-52, and assistant to the chief of medicine at the VA Hospital, Louisville, from 1952-54.

William C. Adams, M.D., of Ridgewood, New Jersey, has been appointed to the full-time faculty of the University of Louisville School of Medicine. He will serve as Instructor in Child Health under the direction of Alex J. Steigman, M.D., chairman of the Department of Pediatrics. Dr. Adams was graduated from Temple University School of Medicine in 1947 and acquired his pediatric training at the University of Illinois and at Temple University.

Buford Hall, M.D., of Lexington, has accepted a full time academic position at the University of Illinois College of Medicine in Chicago. He had been associated with Rankin C. Blount, M.D., for the practice of internal medicine in Lexington.

Bernard J. Schoo, M.D., recently announced the opening of his office in Louisville limited to the practice of general surgery. A graduate of the University of Louisville School of Medicine in 1946, Dr. Schoo interned at St. Joseph Infirmary, Louisville. From 1947-49, he served with the United States Navy. He took a residency in general surgery at St. Joseph Infirmary, Louisville, from 1949-50, and further training at General from 1950-54.



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1. Zupko, A. G.: Pharmacology and the General Practitioner, GP 7:55 (March) 1953.

2. McHardy, G. G., and Others: Clinical Evaluation of Methantheline (Banthine) Bromide in Gastroenterology, J.A.M.A. *147*:1620 (Dec. 22) 1951.

WASHINGTON NEWS DIGEST

Washington, D. C.—Although the elections back home are more stimulating than Washington doings these fall weeks, some of the quiet planning going on at the Pentagon should be of more than passing interest to physicians, young and old. The objecitves are familiar: First, to insure a steady supply of physicians for the services; second, to improve the medical care program for military dependents. Primarily responsible for working things out are Dr. Frank Berry, Assistant Secretary of Defense for medical affairs, and the officers assisting him.

To insure that the services will get the physicians they need after the scheduled expiration of the Doctor Draft Act next July 1—without disrupting residency training—a plan bearing the formidable name of the Armed Forces Reserve Medical Officer Commissioning and Residency Consideration Program has been put into effect. It applies only to interns who have had no prior military service, and who therefore have a two-year obligation for service under the regular draft.

The plan's first deadline was October 10. By that time these young physicians were to have sent in to the Defense Department a form with the following information: Their first, second, and third choices among the services, whether they wanted additional deferment for residencies and if so choice of hospitals, and the preferred specialties. Any in this group who do not apply for reserve commissions will be subject to the regular draft, will not be considered for residency deferments, and will not have a choice of services.

There is another problem involved. It is estimated that about half of the interns will want residency deferments. However, not more than a quarter can be deferred if the Army, Navy, and Air Force are to get their quotas of physicians. This is being resolved by a lottery. Those winning deferments will stay in the reserves, and be called up for duty as their specialties are needed after the completion of their residencies. Those losing out will be called as needed at the end of their internships. The 50% not asking for deferments will be

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allowed a choice of the month to be called up, a privilege not accorded the others.

On the dependent medical care program, Dr. Berry's annual report discloses that the Department is all set to put the expanded plan into operation, should Congress enact it. An implementing directive has been drawn up, a tentative fee schedule modeled on the VA "Guide for Medical Services" has been prepared, and a uniform "Military Dependent Identification Card" has been developed and placed in limited use by the Navy and Air Force.

A dependent care bill was introduced last session, but not pressed by Defense Department. It provides a uniform program for the three services, with dependents defined and the extent of care limited. It also would have the military medical departments take care of all the dependents they could handle, with only the remainder going to private physicians and hospitals. The American Medical Association believes this should be reversed, with emphasis on private, non-government care for dependents.

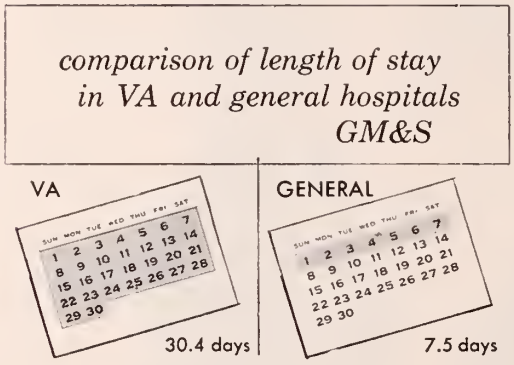
The Defense Department is interested in other devices to keep up the quality as well as the number of its physicians. One of these is a scholarship program, which would require one year of military service for each scholarship year. Because regular draft time could be served out this way, any scholarship contract would call for a minimum of three years' active duty. The Department has high hopes that this program will be authorized by the next Congress. It also is hopeful that, once in operation, the scholarship contracts would result in more young physicians joining the regular Army.

Meanwhile the Hoover Commission on Organization of the Executive Branch and the Kestnbaum Commission on Intergovernmental Relations continue with their studies and report-writing, efforts that now are definitely unspectacular but that ultimately could mean important changes in the government's medical programs.

The Hoover Medical Task Force is nearing the end of its long review of all federal medical operations. Its recommendations will be submitted to the full commission for consideration in the commission's report to the President, due at the White House next May.

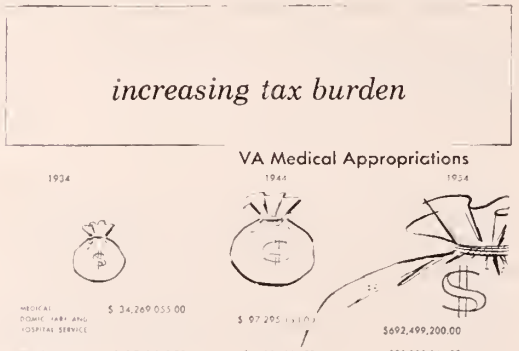
The Kestnbaum commission's work of greatest medical interest is the study of health grants-in-aid, on which a special committee has just completed its report. The full commission is scheduled to report back to Congress by next March.

In Viewing the VA Medical Program . . .



General medical and surgical patients in VA hospitals are confined four times longer than in non-federal hospitals. VA hospitals admit patients for examination, diagnosis, and treatment, much of which is normally undertaken outside civilian hospitals. Also, VA patients often remain hospitalized throughout the entire medical treatment period, whereas non-VA patients are usually treated at home during their convalescence. This is a major factor in the tremendous cost of the VA medical program.

In Viewing the VA Medical Program . . .



In twenty years, the cost of the VA medical program to U. S. taxpayers has increased 1,875%. Yet only 15% of the patients treated in VA hospitals are veterans with disabilities incurred while in uniform. The VA medical program is now second in size and expense only to the nation-wide system of socialized medicine in Great Britain.

In Memoriam

LARREN RAY ELLARS, M.D.

Louisville

1893 - 1954

Dr. Ellars, 62, a surgeon in Louisville for more than 35 years, died September 22, 1954, at the New England Baptist Hospital, in Boston, where he had gone for an operation.



Dr. Ellars

Dr. Ellars was one of four Louisville surgeons named fellows of the International College of Surgeons in 1947. A native of Peru, Indiana, Dr. Ellars was graduated from the Louisville Medical School in 1915 and did graduate work at the University of Pennsylvania.

He has had scientific papers published in the American Journal of Surgery, the International Journal of Surgery, the Journal of the Southern Medical Association, and the Journal of the Kentucky State Medical Association.

He was surgeon for several Louisville companies, including the Louisville & Nashville Railroad, the Louisville Gas & Electric Company and the Southern Railway.

In 1918 he enlisted in the Active Medical Corps (Reserve) of the U. S. Army. Mrs. Ellars has in her possession several important letters of commendation to the Surgeon General of the U. S. Army recounting the many qualifications that were a credit to Dr. Ellars.

ERNEST COLE, M.D.

Winchester

1879 - 1954

Dr. Cole, 75, who had practiced in Winchester for 49 years before his retirement in February, died September 26. He had served several times as president of the Clark County Medical Society and was on the County Board of Health.

Dr. Cole was instrumental in founding the Clark County Hospital and had served as a director. He was a deacon in the First Baptist Church of Winchester. Dr. Cole was graduated from the University of Louisville Medical Department in 1905.

JAMES CANTRILL CARRICK, M.D.

Lexington

1867 - 1954

Dr. Carrick, retired Lexington physician, died September 20, 1954. He had practiced in Lexington for 60 years.

He was chairman emeritus of Transylvania College's board of curators executive committee, a member of the Good Samaritan Hospital staff, and a director of the First National Bank & Trust Company.

For many years he was president of the Lexington Board of Health, and was a former surgeon general of the Kentucky National Guard. He had extensive landholdings in Scott and Fayette counties.

ILMA HASTIE, M.D.

Harlan

1900 - 1954

Dr. Hastie, Harlan physician, was killed September 12, 1954, when her automobile struck a bridge abutment near Pineville. Dr. Hastie was vice-president of the Kentucky State Parent Teachers Association.

She was graduated from Washington University School of Medicine, St. Louis, Missouri, in 1930. Dr. Hastie interned at St. Anthony's Hospital, Terre Haute, Indiana. She was a former resident of Owensboro and the daughter of the late James H. Thorpe, M.D., who practiced there.

CHARLES WILLIAM HIBBITT, M.D.

Louisville

1871 - 1954

Dr. Hibbitt, teacher and counselor of medical students at the University of Louisville for nearly 50 years and in active practice for 61 years, died August 26, 1954, at the Kentucky Baptist Hospital, Louisville.

He had retired from teaching in 1947, but maintained his practice of obstetrics and gynecology until his final illness. Dr. Hibbitt was graduated from the Louisville Medical College in 1897 and began teaching in 1902. For 20 years he was chairman of the Department of Obstetrics and Gynecology of the University of Louisville School of Medicine and was a member of the faculty for 45 years.

He served in Puerto Rico during the Spanish-American War, in the campaign against Mexico, and during World War I in France. Dr. Hibbitt was a member of the Jefferson County Medical Society, the Kentucky State Medical Association, the American Medical Association and the American College of Surgeons.

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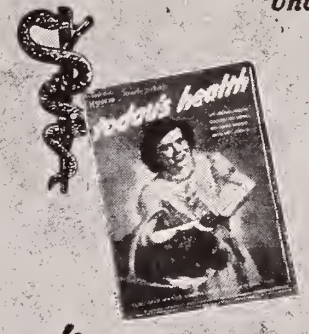
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County Society Reports

BOYLE

The Boyle County Medical Society held its September meeting at the Boyle County Health Department, September 28, 1954. Dr. S. B. Sharp, president, called the meeting to order.

A call system for the physicians was discussed. Each physician is to have as his call number at basketball games, football games, movies, etc., the last two numbers in his office telephone number. A motion was made that such a plan be adopted and was unanimously passed.

A certificate of Life Membership was presented to Walter O. Hopper, M.D. The credentials of Charles Sisk, M.D., John Beard, M.D., and Lloyd May, M.D., were presented and it was moved that the secretary cast one vote for their membership into the Boyle County Medical Society. The motion carried.

Richard S. Ahrens, M.D., of Kentucky State Hospital, presented a program on the legislative measure passed during the past three years in Frankfort, and explained how much this had meant to the four mental hospitals in Kentucky, especially since no appointment is on a political basis but on a merit basis. Many facts were presented, such as Kentucky Central Hospital occupies more than 2,000 acres with an annual budget of around $1,800,000.00.

Physicians attending the meeting included: P. C. Sanders, W. O. Hopper, B. E. Caywood, Louis J. Beto, S. P. Hemphill, Richard Jackson, Chris Jackson, A. M. Jester, G. M. McClure, Richard S. Ahrens, Charles W. Sisk, Lloyd P. May, Bill Sanders, Robert C. Bateman, John Beard.

Chris S. Jackson, M.D., Secretary

McCRACKEN

The regular meeting of the McCracken County Medical Society was held September 15, 1954, with Keith Sloan, M.D., presiding.

The scientific speaker, J. O. Lottis, M.D., instructor of orthopedics at Washington University, St. Louis, Missouri, was introduced by W.

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M. Turner, M.D. Dr. Lottis discussed "Intramedullary Fixation."

A letter was read from the Galen Club, Long Beach, California, relative to veterans' hospital care for non-service connected disabilities. The society voted to endorse the resolution by the Galen Club and to notify the local Chamber of Commerce of their action. It was moved that the resolution be turned over to the local representative, R. W. Robertson, M.D., to carry through the motion at the optimum time after discussing the matter at state levels. Dr. Robertson will report to the society at the next meeting.

Ben Bradford, M.D., was admitted to the society by unanimous vote. The floor was opened to J. V. Pace, M.D., for discussion on any controversial subjects which might arise at the KSMA meeting.

The report by Dr. Marshall on the Cerebral Palsy Committee informing the society of the present status of the cerebral palsy center situation was discussed by Keith Sloan, M.D., and Samuel French, M.D.

It was moved that the society endorse the cerebral palsy center. The motion was amended that the society offer services to any organization so concerned with furthering the advancement of the center.

M. W. Fowler, M.D., Secretary

PIKE

The regular Pike County Medical Society meeting was held at Langley's Cafe, Pikeville, September 14, 1954, with 24 members present. President Charles C. Rutledge, M.D., called the meeting to order.

The fee schedule with the United Mine Workers Welfare Association was discussed by the members. It was generally agreed that the existing fee schedule was not satisfactory to the society.

G. N. Combs, M.D., moved that the Pike County Society not enter into any fee schedule with the UMWA for an all inclusive plan for medical care. The motion carried. It was further moved that a three member committee be appointed by the president to talk with Clark Bailey, M.D., and Carl Fortune, M.D., or other



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state officials in regard to specific problems encountered in eastern Kentucky with the UMWA Welfare and Retirement Program, and submit a report at the next meeting. The motion carried.

The following physicians agreed to go to Lexington or Louisville to discuss the problem: A. G. Osborne, M.D., W. F. Clarke, M.D., G. N. Combs, M. D., William Hambley, M.D., C. F. Wilson, M.D., and J. P. Darling, M.D.

Roy Sanders, M.D., presented a recommendation that the secretary be instructed to write the insurance companies in regard to their delay in the payment of bills as well as the actual payment and guarantees not being compatible with the promises made by the insuring agent. The motion failed to pass.

Russell H. Davis, M.D., Secretary

SHELBY-OLDHAM

The Shelby-Oldham County Medical Society met at the Old Stone Inn, September 16, 1954, with L. B. Sternberg, M.D., as host. L. A. Wahle, M.D., vice-president, called the meeting to order.

The secretary read a letter from Woodford B. Troutman, M.D., Louisville, of the Kentucky Heart Association, in regard to a class to be formed in Shelbyville for instructing women cardiac patients. This will be known as the "Heart of the Home" program. The society voted approval of this program.

Dr. Wahle described a program to be put on by the Kentucky State Medical Association for the instruction of physicians' office assistants. The society approved the plan. The first class will be held at the October meeting.

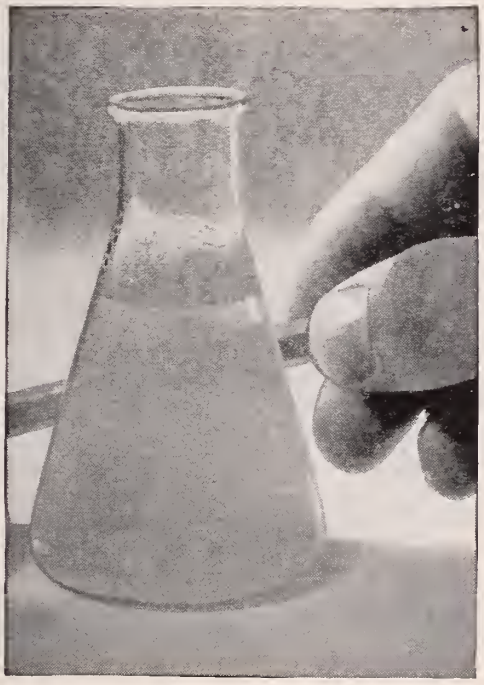
H. B. Mack, M.D., reported on an insurance plan that the Academy of General Practice is fostering. No action was taken.

Dr. Sternberg introduced the scientific speaker, Dr. Diamond, of Louisville, who spoke on the topic, "Why Infants Die."

In addition to those mentioned, the following members and guests were present: B. F. Shields, M.D.; A. C. Weakley, M.D.; A. D. Doak, M.D.; Don Chatham, M.D.; M. D. Klein, M.D.; George Perrine, M.D.; Charles Chatham, D.D.S.; A. L. Heise, D.D.S.; M. H. Skaggs, M.D.; H. T. Alexander, M.D.; R. M. Whitaker, D.D.S.; E. G. McMunn, M.D.; R. L. Houston, M.D.; S. B. May, M.D., J. H. Faust, of Erie, Pennsylvania.

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1. *American Medical Association: New and Nonofficial Remedies, 1954. J. B. Lippincott Co., Philadelphia, p. 147*
2. *Scott, R. L., and others: Antibiot. & Chemo. 4:691 (June) 1954*

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SCOTT

The regular monthly meeting of the Scott County Medical Society was held on Thursday, October 7, at the John Graves Ford Memorial Hospital in Georgetown. The following physicians were present: E. C. Barlow, H. G. Wells, F. W. Wilt, J. Campbell Cantrill, W. S. Allphin, A. F. Smith and H. V. Johnson.

Dr. Wells, delegate from Scott County to the State Medical Meeting, gave a report on the meeting. Among other things he reported a change in the by-laws which will allow the KSMA to put the state society dues of $35.00 per year on a permanent basis. He also reported on a number of questions that were brought up for discussion before the House of Delegates.

Dr. Cantrill reported that he had been visited by a Citizens Committee from Sadieville, asking that one or more physicians from Georgetown serve part time in Sadieville. This met with the approval of the society and the secretary was instructed to write to the chairman of the committee, saying that we are anxious to help in any way to provide medical care for the people of that community.

H. V. Johnson, M. D., Secretary

WARREN-EDMONSON

The Warren-Edmonson County Medical Society held its regular meeting September 14, 1954, with R. O. Green, M.D., presiding. The death of Eldon Stone, M.D., was brought to the attention of the society, and the fact that George T. Proctor, M.D., had entered the army.

The society gave its approval to the Kentucky Heart Association's sponsorship of a Clinic in cooperation with the Rural Electrification Program for the benefit of housewives who have heart disease.

The society approved the dinner meetings for their secretaries, to be sponsored by the Kentucky State Medical Association, for presenting public relations information and other material this fall.

G. Y. Graves, M.D., gave a report on some of the medical meetings he attended in Europe during the summer.

Charles M. Francis, M.D., Secretary

BOOK REVIEWS

CHILDREN FOR THE CHILDLESS—Edited by Morris Fishbein, M.D.

This 211 page book is published by Doubleday & Company, Inc., Garden City, New York. It consists of eight chapters, each chapter being contributed by one or two prominent authors most of whom are well-known men such as Morris Fishbein, I. C. Rubin, Nicholson J. Eastman, and J. P. Greenhill. The chapter headings are concerned with: 1, "On Being a Parent Today," 2, "Physical Aspects of Fertility and Sterility," 3, "Psychosomatic Aspects of Fertility and Sterility," 4, "Human Sterility," 5, "Human Fertility," 6, "Artificial Insemination," 7, "Adoption," 8, "What Will Our Child Be Like?"

There is some overlapping from chapter to chapter and author to author which is inevitable, I suppose since there are numerous contributors to the same book. It seems to me that book would appeal mostly to the "eager beaver" type of person, the type of person who reads a good deal of borderline medical literature. The book could be of considerable general value to physicians. To me, the book is neither "fish nor fowl." That is to say that it is not a high class text book and is perhaps a little too scientific and technical for the average layreader.

Reviewed by W. E. Oldham, M.D.
Louisville

A conference on silicosis and occupational chest diseases jointly sponsored by the McIntyre Research Foundation of Toronto, Canada, and the Saranac Laboratory of Saranac Lake, New York, will be held February 7-9, 1955, in Saranac Lake. Papers to be presented will represent original work conducted by these organizations.

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*Heck, W.E.; Lynch, W.J., and Graves, H.L.: Acta oto-laryng. 43:416, 1953.

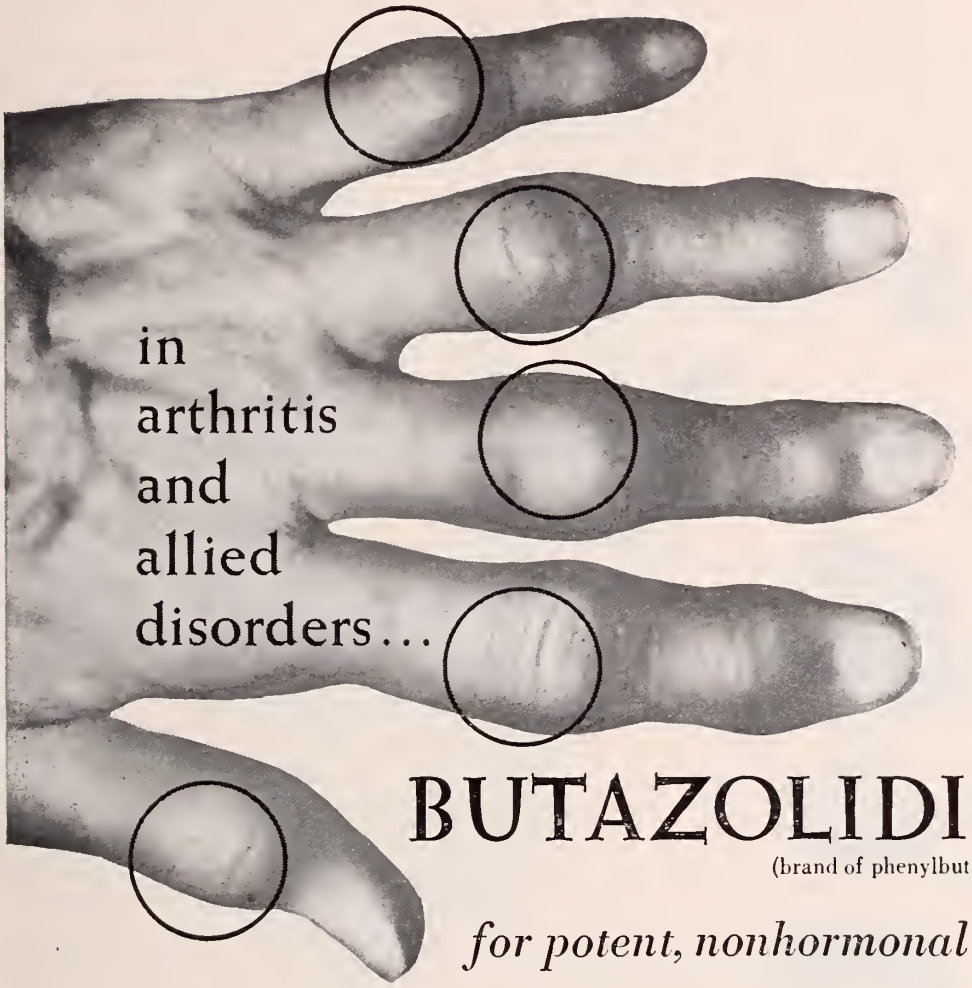
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*MacKnight, J. C.; Irby, R., and Toone, E. C., Jr.: Geriatrics 9:111 (Mar.) 1954.

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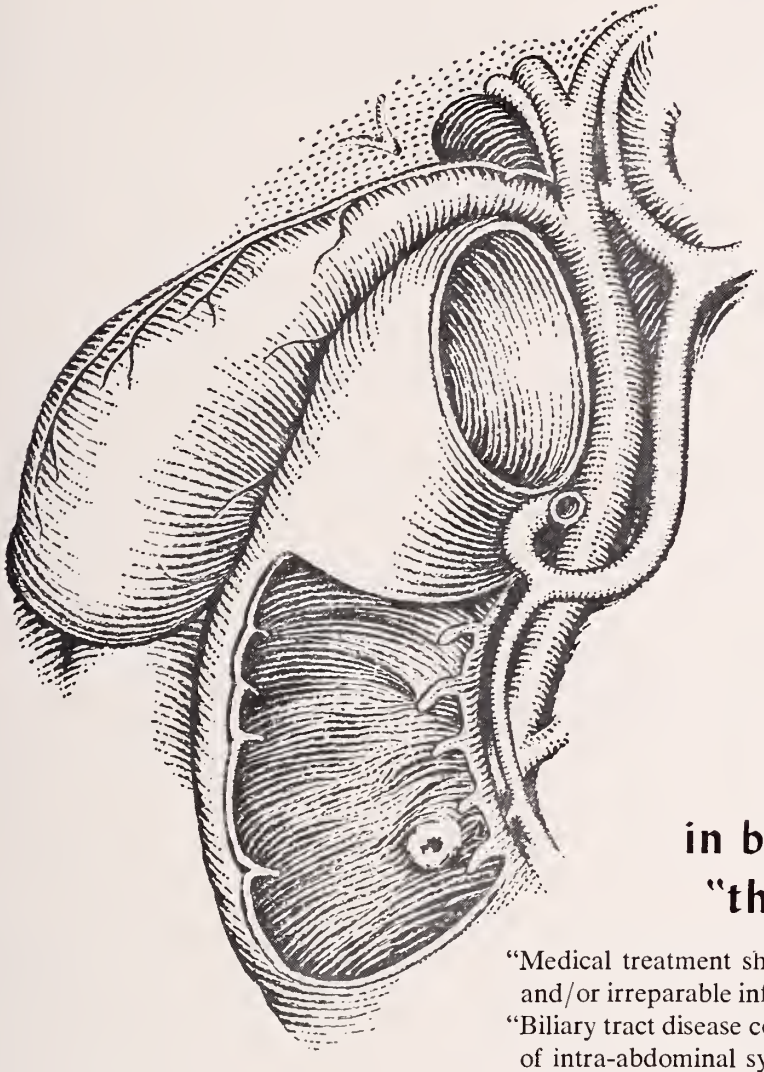
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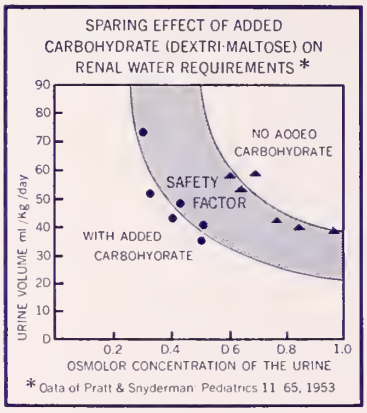
1. Segal, H.: Postgrad. Med. *13*:81, 1953. 2. O'Brien, G. F., and Schweitzer, I. L.: M. Clin. North America *37*:155, 1953. 3. Beckman, H.: Pharmacology in Clinical Practice, Philadelphia, W. B. Saunders Company, 1952, p. 361.

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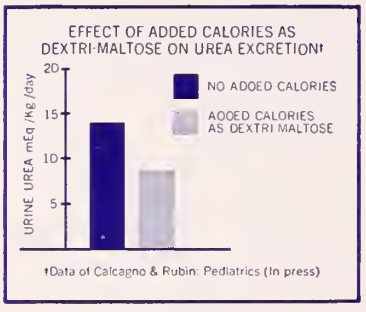
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1. Pratt & Snyderman: Pediatrics 11: 65, 1953; 2. Calcagno & Rubin: Pediatrics (in press); 3. Calcagno, Rubin & Weintraub: J. Clin. Investigation 33: 91, 1954; 4. Caake, Pratt & Darraw: Yale J. Biol. & Med. 22: 227, 1950; 5. Gamble: J. Pediat. 30: 488, 1947; 6. Rappaport: Am. J. Dis. Child. 74: 682, 1947.

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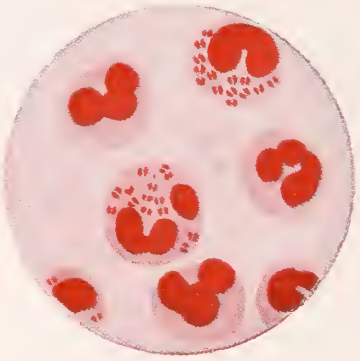
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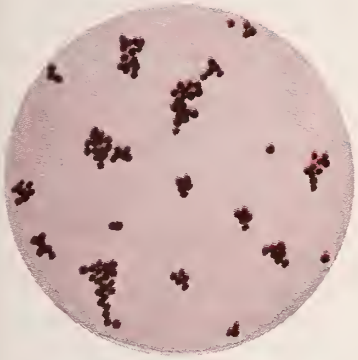


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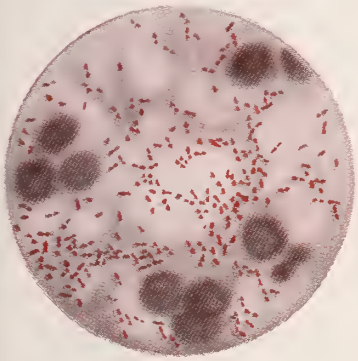
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(1) Yow, E. M.; Taylor, F. M.; Hirsch, J.; Frankel, R. A., & Carnes, H. E.: *J. Pediat.* **42**:151, 1953. (2) Dodd, K.: *J. Arkansas M. Soc.* **10**:174, 1954. (3) Hanbery, J. W.: *Neurology* **4**:301, 1954. (4) Miller, G.; Hansen, J. E., & Pollock, B. E.: *Am. Heart J.* **47**:453, 1954. (5) Keefer, C. S., in Smith, A., & Wermer, P. L.: Modern Treatment, New York, Paul B. Hoeber, Inc., 1953, p. 65.



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WASHINGTON NEWS DIGEST

Washington, D. C.—With the change in control of Congress, there naturally will be a major reshuffling of all committees, including those handling medical and health legislation. A new chairman moves to the top, and at the bottom a few Republican members drop off, to be replaced by an equal number of Democrats. In a Congress so evenly divided, domination of this committee machinery is a vital asset.

A majority of the Democrats taking over committee chairmanships in January will be returning to the same jobs they held when their party was in power before, but the situation is a little different on the two committees most important in health and medical legislation. It will be the first time either of these chairmen has had the responsibility of running the full committee, although both have been involved in medical legislation for many years. Both are veteran legislators and are Southerners. They are Senator Lister Hill of Alabama, who replaces Senator H. Alexander Smith of New Jersey as chairman of the Labor and Welfare Committee, and Rep. Percy Priest of Tennessee, who succeeds Chairman Charles Wolverton, also of New Jersey, on the Interstate and Foreign Commerce Committee.

By reason of seniority, Senator James Murray of Montana is in line for the Labor and Welfare Committee chairmanship. However, he has announced that he prefers to run the Interior and Insular Affairs Committee, thus turning over the other chairmanship to Senator Hill. Senator Murray, as a sponsor of national compulsory health insurance, and as a chairman and member of its committee that held such turbulent hearings on this subject, became well known to the medical profession.

Senator Hill, the son of a physician, has been in Congress for 30 years—14 in the House before he came to the Senate. He was a co-sponsor of the Hill-Burton hospital construction program, perhaps the most important piece of medical legislation enacted since World War II.

Presumably the Senate committee's Health Subcommittee again will be headed by Senator Herbert Lehman of New York, who handled this task during the last Democratic Congress, the 82nd. Last session the Health Subcommittee chairman was Senator William Purtell of Connecticut.

Mr. Priest is a former school teacher and newspaperman. He has been in the House for seven uninterrupted terms. In 1951 he was chairman of the Commerce Committee's Health Subcommittee; the subcommittee system was abolished by the committee in 1952. Since then he has taken an extremely active part in committee work in the health and medical fields.

The Hill and Priest committees will handle most health legislation with the exception of military, veteran and appropriation bills. For example, they will be in charge of reinsurance if it is reintroduced, as well as most health-medical bills originating in the Department of Health, Education and Welfare.

A number of other committee changes of importance to medical legislation are scheduled. Rep. Edith Nourse Rogers of Massachusetts, a veteran of 29 years in the House, loses the chairmanship of the Veterans Affairs Committee. She is being succeeded by Rep. Olin Teague of Texas, who was elected to Congress for the first time while he was completing his six-year Army duty in 1946.

The House Appropriations Committee chairmanship goes from Rep. John Taber of New York to Rep. Clarence Cannon of Missouri; both have the reputation of being economy-minded. Of considerable significance in medical appropriations is the change in the chairmanship of the subcommittee that handles money for the Department of Health, Education and Welfare. The chairman for the last two years, Rep. Fred Busbey of Illinois, carefully scrutinized all health appropriations, and effected many reductions. He was defeated for re-election. The prospective chairman of the subcommittee, Rep. John Fogarty of Rhode Island, repeatedly has intervened in the committee and on the House floor to restore money cut out by the subcommittee.

Chairman of the Armed Forces Committee in the Senate—where medical care for military dependents would be taken up—will be Senator Richard B. Russell of Georgia, replacing Senator Leverett Saltonstall of Massachusetts. On the House side, the Armed Forces chairmanship goes to the veteran Rep. Carl Vinson, also of Georgia. He replaces Rep. Dewey Short of Missouri.

Any bills proposing reorganization of the executive departments will come before Chairman John L. McClellan of Arkansas in the Senate and Rep. William L. Dawson of Illinois in the House. They are succeeding Senator Joseph R. McCarthy of Wisconsin and Rep. Clare E. Hoffman of Michigan.

Entered as second-class matter, Oct. 22, 1906, at the Post Office at Bowling Green, Ky., under act of Congress, Mar. 3, 1897. Acceptance for mailing at special rates postage provided in Section 1103, act of Oct. 3, 1917, authorized May 25, 1920.

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References:
1. Hollander, F.: Arch. Int. Med. *93*:107 (Jan.) 1954
2. Deutsch, E.: Scientific Exhibit, Gastroscopy, Clinical Meeting A.M.A., St. Louis, December, 1953

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(a) Figures involving dividends apply to policies issued on or after May 1, 1954 and are not guaranteed but are merely illustrations based upon current experience.

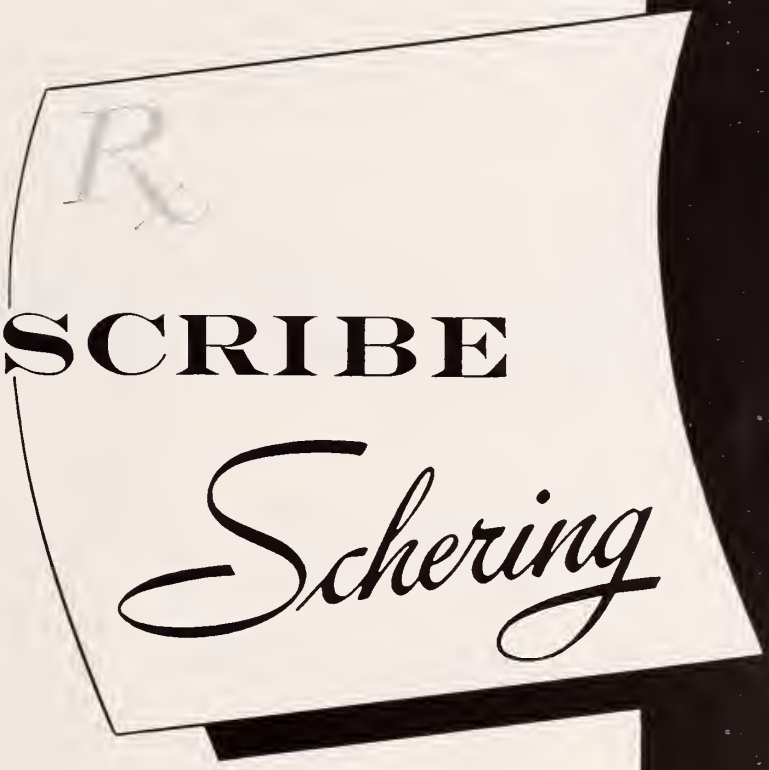
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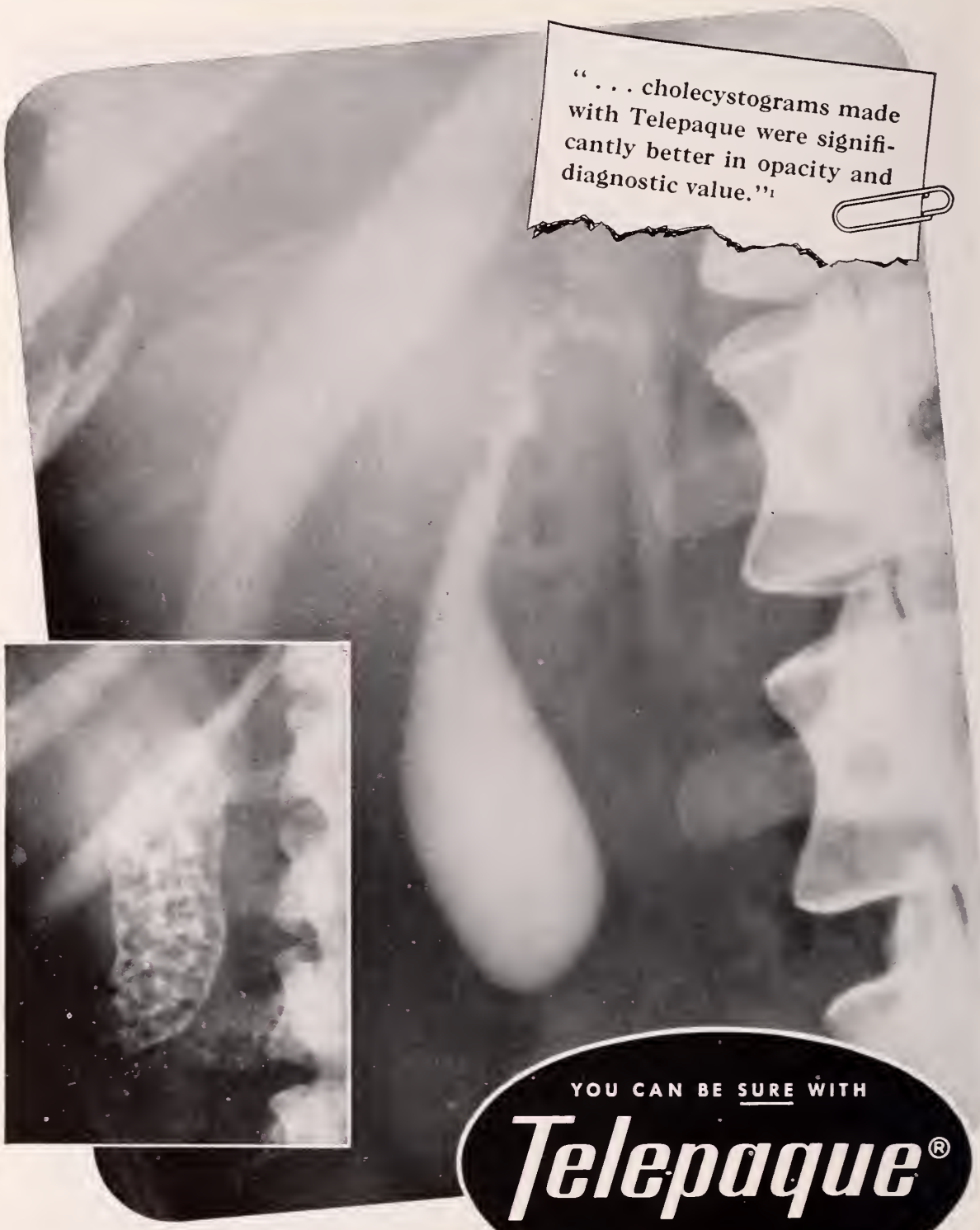
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1 Abel, M.S., Lomhoff, I.I., and Garcia, C.V.: *Permanente Found. Med. Bull.*, 10:95, Aug., 1952.
2 Lowman, R.M., and Stanley, H.W.: *Connecticut Med. Jour.*, 16:591, Aug., 1952

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1. Malleson, J.: Lancet 2:158 (July 25) 1953. 2. Goldzieher, M. A., and Goldzieher, J. W.: Endocrine Treatment in General Practice, New York, Springer Publishing Company, Inc. 1953, p. 23.

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The JOURNAL of the

Kentucky State Medical Association

Issued Monthly Under the Direction of the Council

VOL. 52 DECEMBER, 1954 NO. 12

Medical Management of Acute Myocardial Infarction*

George W. Pedigo, Jr., M. D. - F.A.C.P.**

Louisville

Coronary thrombosis is the cause of death of at least 200,000 people[1] a year in the United States. It strikes frequently and unexpectedly, at a time when the individual has his greatest responsibility toward his home and his business. It is encountered at any age, but it occurs most frequently after the age of 40.

Etiology

The etiology of coronary occlusion is usually a primary narrowing of the lumen of the involved coronary artery by arteriosclerosis, with thrombosis occuring secondarily. The heart muscle that is dependent on this particular branch of the coronary circulation becomes ischemic and subsequently necrotic. If the coronary vessel occluded is small, the patient will likely recover. If the involved coronary vessel is large, sudden death may result from the myocardial infarction per se. If the patient survives the initial onset of the occlusion, complications and death may still occur as the result of rupture of the heart, shock, arrythmias, congestive heart failure or as the result of secondary thromboembolic phenomena. These secondary thromboembolic phenomena may include:

1. Formation of mural thrombi on the endocardial surface at the site of the infarction, which may cause emboli to the brain, kidneys, spleen, legs, or elsewhere.

2. Phlebothrombosis, especially in the legs, with emboli to the lungs.

3. Extension of the original thrombus with further infarction of the myocardium.

The therapy of the patient with an acute coronary occlusion with myocardial infarction should have as its goal:

1. The relief of the pain, anxiety, and restlessness of the patient.

2. To reduce the load on the heart as much as possible.

3. To prevent or treat shock.

4. To prevent secondary thromboembolic complications.

5. To prevent or treat congestive heart failure.

6. To prevent or treat various cardiac arrythmias that may occur.

Therapy

The therapeutic management will be considered under a few basic headings.

1. Sedation - The patient with an acute coronary occlusion is usually in severe pain and he is extremely apprehensive and restless. The severe pain may cause peripheral vascular collapse with shock[2] so it is important to relieve the pain as soon as possible. Morphine sulfate, Pantapon, or Dilauded are the drugs of choice, initially, to relieve the pain. One of these drugs should be used as needed for the first few days. As the pain disappears barbiturates or chloral hydrate should be substituted for the opiates to control the apprehension and restlessness.

2. Oxygen - Oxygen is especially indicated if there is evidence of appreciable pain, dyspnea or cyanosis. Oxygen should not be reserved as a life saving gesture but should be used early and routinely, if possible, to save the myocardium any

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unnecessary labor. In the presence of pulmonary edema positive pressure oxygen is a valuable adjunct to therapy.

3. MANAGEMENT OF SHOCK - An important cause of death within the first 24 - 48 hours after a coronary occlusion is profound hypotension with the clinical manifestations of medical shock. The shock state occurs in approximately 10% of all cases of myocardial infarction[3] and has a mortality rate of 80-90%[4,5]. In acute coronary occlusion there is a sudden fall in cardiac output[6,7] with a reduced coronary blood flow[8]. Peripheral vascular collapse is a secondary factor. Stead and Ebert[9] have observed in patients with myocardial infarction a simultaneous diminution of peripheral blood flow and congestion of the pulmonary or systemic circulation. This reflects a primary failure of cardiac output in myocardial infarction and not a reduction in the venous return to the heart, which characterizes other varieties of shock.

The basis of therapy for shock, secondary to an acute coronary occlusion, rests with measures which will promptly restore an effective blood pressure and an adequate coronary blood flow. The rationale of the intravenous administration of plasma, whole blood, or glucose, in many cases, is dubious. The venous return to the heart, in most instances, is adequate, and congestive heart failure with pulmonary congestion, elevated venous pressure, and even pulmonary edema, may accompany the shock state. In these cases the intravenous administration of fluids would only increase the venous return and augment the symptoms. If there is no evidence of pulmonary congestion, and the patient has a normal venous pressure, whole blood or plasma transfusions have been given with some success[10]. The rate of intravenous flow must be carefully watched to prevent acute pulmonary edema. The results of intravenous transfusions have not been striking. A myocardium weakened due to insufficient coronary blood flow may be markedly helped, in some instances, by giving plasma or blood intra-arterially[4]. This makes possible effective perfusion of the coronary arteries, and cerebral circulation, with a relatively small amount of blood.

Vasopressor drugs may also be used in an effort to restore an effective blood pressure. Norepinephrine (Levophed-Winthrop-Stearns) has an advantage over older drugs like epinephrine, ephedrine and neo-synephrine. Norepinephrine[11] produces peripheral vasoconstriction, slows the heart rate when the vagi are intact, increases coronary blood flow, and does not significantly change cardiac output. Norepinephrine may be given intravenously after diluting 4 mg. of Levophed in 1000 cc. of 5% glucose in water. This may be given intravenously at the rate of 10 drops per minute. The blood pressure should be checked frequently, with an attempt to keep the systolic blood pressure at about 100 mm. Hg. Sympathetic amines, as mephentermine (Wyamine), have been reported[3] to produce, also, a significant pressor response in patients in shock from an acute myocardial infarction. According to Hellerstein & Brofman[12], 5-15 mg. of mephentermine may be given, initially, intravenously followed by 35-70 mg. diluted in 100 cc. of 5% glucose and given slowly intravenously over the next few hours, the rate of flow depending on the response of the blood pressure. Intramuscular injection of 25 mg. of mephentermine every one to two hours may be needed to maintain the blood pressure.

4. REST - Rest is one of the most important and essential procedures in the treatment of a patient with a recent coronary occlusion. A myocardial infarct goes through stages in which ischemia is followed by necrosis of the heart muscle. It takes a considerable time for fibrosis, scarring and collateral circulation to restore the heart muscle to anything like its former strength. It is necessary, therefore, to keep the work of the heart at a minimum. Bed rest is advocated for 3 to 8 weeks depending on the severity of the individual case. A bed side commode, however, may be used after the first few days. An occasional patient will be more relaxed, and will rest better, if allowed to sit quietly in a lounge chair part of the day. Gradual ambulation of the patient, after the prescribed period of bed rest, is important. An attempt is made to rehabilitate the patient to his old job with a sensible slowing of his pace. Generally speaking, it is the pace and not the job that is important.

5. ANTICOAGULANT THERAPY - In a summary of the findings in 1031 cases of myocardial infarction, Wright[13] has concluded that anticoagulants, correctly used, exert a markedly favorable influence on both the death rate, and on the thromboembolic complications, for cases surviving the initial impact of the attack.

The death rate for the control cases, in Wright's report, was 23.4%. The death

rate, for the cases treated with anticoagulants, was 16%. In addition to the deaths, the incidence of thromboembolic complications was reduced from 26% in the control cases to 11% in the treated cases. Bleeding, believed due to or aggravated by anticoagulants, averaged 9 episodes per 100 cases. Most of these bleeding episodes were minor with only 4 severe episodes reported. It would appear that anticoagulant therapy should be used routinely, unless specific contraindications exist.

Heparin may be given intravenously in doses of 50-75 mg. every 4 hours until the action of Dicumarol is evident, at which time heparin is discontinued. Dicumarol is started at the same time the initial dose of heparin is given. A prothrombin time should be taken before the first dose of Dicumarol, and each succeeding morning before the daily dose of Dicumarol is determined. Ideally, the prothrombin time should be kept between 25-39 seconds or 2 to 2½ times the control prothrombin time, if the control is 12-18 seconds.

Tromexan may be used in place of Dicumarol. Tromexan acts more quickly than Dicumarol and does not have so lasting an effect. It has the disadvantage of being prone to cause rapid fluctuation in prothrombin levels[14], and is more expensive.

Hedulin is another anticoagulant which may be given orally. It also is absorbed and excreted more rapidly than Dicumarol.

6. Other Drugs - In general, the treatment of congestive heart failure, in the presence of a myocardial infarct, should not differ from its treatment under other circumstances. Digitalis should not be withheld if congestive heart failure, or auricular fibrillation with a rapid ventricular rate occurs.

Quinidine is indicated in the presence of cardiac irritability with numerous premature contractions, either auricular or ventricular. Pronestyl may be used when ventricular arrythmias occur.

Atropine, papaverine and aminophyllin are all of questionable value.

7. General Measures - A low sodium diet should be prescribed if there is any evidence of congestive heart failure.

A low caloric diet is indicated if the patient is overweight.

A low cholesterol and low fat diet has been advocated, especially by Morrison[15]. Keys[16], recommends avoidance of obesity and restriction of fats but thinks dietary cholesterol on the whole may be disregarded.

It is recommended that tobacco be omitted.

Summary

The management of the patient with coronary occlusion and myocardial infarction has been discussed. The value of rest, oxygen, sedation, and anticoagulant therapy has been outlined. The treatment of the shock state in myocardial infarction and the use of certain drugs, which are occasionally indicated, is presented.

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Roentgenology in Obstetrics

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The value of diagnostic x-ray in obstetrics depends upon the interest and cooperation of both the obstetrician and the roentgenologist. In some instances the roentgenologist's experience in the field of obstetrics may be limited. Such a situation can, of course, lead to somewhat less than the best in obstetrical x-ray examinations until adequate experience has been obtained. On the other hand, a number of obstetricians have expressed the opinion that x-ray is of little value although they may never have experienced optimal diagnostic roentgenological service.

Technically poor films have also brought considerable discredit to the value of x-ray in this field. Obviously, the most meticulous attention to technical details must be employed to get maximal results, especially in soft tissue studies.

Many of the diagnoses made by x-ray, such as multiple pregnancies, polyhydramnios, fetal malformations, etc., are too obvious to warrant more than passing mention. Fetal bones are seldom demonstrable before the 14th week of gestation, although pressure of an enlarged uterus on the contrast-filled bladder may be seen much earlier.

Placental apoplexy may be identified by a localized bulge on the uterine contour. This is especially valuable when the hemorrhage is posterior, for such is not palpable through the abdominal wall.

Fetal death is usually easily confirmed by x-ray. Overlapping of the fetal cranial bones is the earliest and most reliable sign, occuring 3 to 4 days after death. Some caution must be exercised in using this sign since overlapping has been observed frequently in labor and occasionally before labor. Some authorities (1) suggest that overlapping of the frontal bones may never occur in the living fetus. Spinal angulation, thoracic collapse and fetal skeletal disorganization eventually occur.

Abdominal pregnancies that approach term are often marked by unusual fetal attitudes. The lie is usually transverse with the dorsum cephalad and the extremities caudad (2). This is the reverse of the situation seen with an intrauterine transverse presentation. Naturally, a full thickness uterine wall (approximately 0.5 cm.) is not seen around an extrauterine pregnancy, although with fetal death the amniotic sac thickens greatly and its shadow approaches that of the pregnant uterus. Tubal pregnancy classically terminates before fetal bones become visible. Therefore, the only evidence of its presence is a soft tissue mass. The extrauterine location of a pregnancy can be positively identified by injecting an opaque medium into the uterus. Such a procedure may well provoke abortion in instances in which the pregnancy happens to be intrauterine. Demonstration of a small uterine impression on the contrast-filled bladder indicates an extrauterine location of any obvious co-existing pregnancy.

Placenta Praevia

The use of x-ray in the diagnosis of placenta praevia is one of its outstanding values in obstetrics. With good films such a diagnosis can be confirmed or denied in the vast majority of instances.

The normal placenta can be seen, without contrast media, to occupy approximately the upper 1/3 of the anterior or posterior uterine wall in about 90% of cases. The fetus faces the placenta in around 75% of pregnancies. (Absence of such a relationship should suggest the possibility of cephalo-pelvic disproportion). Obviously, the presence of a normally placed placenta rules out placenta praevia.

Generally speaking, the head will not descend into the pelvis when a patient with a central praevia assumes the upright position. This can be an important consideration in differentiating a central from a marginal praevia.

A placenta praevia is visualized as a soft tissue shadow, at least 3 cm. in thickness, between the fetal head and a contrast-filled bladder or rectum. Air is by far the best contrast medium to use, since overlapping contours are easily delineated. About 150 cc. of air adequately distends the bladder. At first, air was not injected into the rectum, and some pos-

*Read before the Lexington Obstetrical and Gynecologic Society on July 30, 1954.

terior praevias were consequently missed.

Polyhydramnios may occasionally give trouble in differential diagnosis since amniotic fluid has the same density to x-rays as does the placenta. With polyhydramnios, however, the fetus will sink into the pelvis when the patient assumes the upright position. After cervical dilatation has occurred the bag of waters may at times be confusing by appearing as a soft tissue mass between the fetal head and the bladder and rectum. Dimpling at the anterior and posterior cervical lips should properly identify the bag of waters as not being the placenta. Posterior fibroids and ovarian cysts can give differential trouble, although they lie posterior and tend to be more spherical. Fibroids also bulge the uterine wall rather than run continuously with it. Anterior fibroids usually rise out of the pelvis as pregnancy progresses.

The diagnosis of placenta praevia by soft tissue studies is virtually impossible unless the head presents. Such patients, as well as those in whom soft tissue roentgenography is inconclusive, may be diagnosed by amniography (3) or placentography (4). In amniography a contrast medium of suitable type is injected directly into the amniotic fluid. This method easily locates the placenta, but is fraught, it seems to me, with considerable danger in the large number of cases (about half) with an anteriorly placed placenta. Placentography is probably less risky. This procedure involves injecting an intravenous contrast medium directly into the aorta or into the femoral artery in a retrograde direction. The placenta is visualized when the injected agent passes through it. Serial films are required, and general or spinal anesthesia is desirable. Fortunately, a diagnosis can be made in most instances without recourse to such specialized maneuvers.

Pelvimetry

Pelvimetry can provide valuable information for the obstetrician. The conduct of a case may be altered completely by the results of such an examination. Let me hasten to say that it is realized that many factors other than fetal and pelvic measurements are involved in the outcome of labor. There is not, and will never be, a satisfactory substitute for sound clinical judgment. Nevertheless, a sensible evaluation of the measurements, with consideration of the effects the pelvis in issue will have on deliverance of the fetus at hand in the presentation seen, may properly lead the obstetrician to section rather than hazard a vaginal delivery, or vice versa.

A detailed discussion of the mathematics of the many pelvimetric methods is hardly indicated in such a presentation as this. I, personally, use Ball's method (5) because of its relative simplicity, acceptable accuracy and (of greatest importance) because it is the method with which I have had the most experience. Many methods, if properly employed, can give good results.

A word about pelvic types is in order. Less than 1/3 of women have a so-called typically female pelvis. Since a mixed pelvis is the rule, maximal value can be derived from the time-honored terms of gynecoid, android, anthropoid and platypelloid if their use is restricted to describing the shape of the inlet. Obviously, a further description of the type of sacrum, the size of the ischial spines, the presence or absence of an acetabular bulge and lateral wall convergence, must be included in the body of the report. The type of subpubic arch is also frequently described, although the obstetrician can obtain this information at least as accurately by clinical examination.

Besides the general description of the pelvis, corrected measurements for the true conjugate and transverse diameters of the inlet, and the bispinous and anterior-posterior diameters of the mid-pelvis (including a posterior mid-sagittal) should be provided. Outlet measurements also can be made easily, but they are frequently omitted since the same information is easily obtained during the physical examination. Localization of the placenta and estimation of the amount of amniotic fluid can sometimes be made from pelvimetry films, although exposures to bring out soft tissue shadows are more revealing in this respect.

The position and engagement, if any, of the fetus should be included in the report. An estimation of fetal age can be made with moderate accuracy. Ball's method for determining the circumference and volume of the fetal head has received widespread acceptance. Charts are available for relating these findings to fetal age. The level of the fundus and the presence of certain ossification centers are also of some value in this respect. An ossification center in the distal end of the humerus, complete ossification of the hyoid bone, ossification of the first segment of the coccyx and the metacarpals all indicate fetal maturity, although any

of these findings may be absent in 25% of cases. Also, perfect technique and a quiet fetus are necessary to reveal such details. Incidentally, having the mother take several deep breaths before she holds her breath for the exposure will help prevent fetal anoxia and resultant movements. It is advisable to have the mother urinate just before an obstetrical x-ray examination; otherwise, a distended bladder may push the fetal head out of the pelvis and occasion unnecessary concern over the lack of engagement.

Finally, a pelvimetry report should contain an impression concerning the presence or absence of cephalo-pelvic disproportion as well as any other factor which might be of value to the obstetrician.

Utero-Salpingography

This examination finds its primary usefulness in sterility studies, although valuable information concerning intrauterine tumors, etc., may be obtained in such a manner. Many individuals have claimed that utero-salpingography has great therapeutic value in the treatment of sterility.

This type of examination can be performed without difficulty in a private office. All that is needed is a special syringe for injecting the opaque medium into the uterine cavity. Any of the recommended opaque agents can give good results so long as the examination is adjusted to the medium used. Twenty-four films are not necessary with rapidly absorbed agents. Great care must be exercised to avoid introduction of gas bubbles into the uterus. Such bubbles may form confusing shadows which often simulate polyps or submucous fibroids. Atropine should be given before the procedure to prevent cornual spasm. Injection pressure should be limited to about 250 mm. of mercury to avoid tubal rupture. Fractional instillation gives the best study of the intrauterine surfaces.

The examination should not be performed until at least a week after the last day of menstruation to avoid injecting the opaque medium into the uterine vascular bed. Active pelvic inflammatory disease is probably a contraindication to this type of study. It must also be remembered that this procedure may cause abortion if the patient is pregnant.

Effects Of Roentgen Radiation

Certainly, large amounts of radiation during the first trimester of gestation can lead to fetal abnormalities or even abortion. This amount, fortunately, is probably over 100 r in most instances. A pelvimetric examination delivers approximately 5 r to the uterine cavity. Therefore, there is a large margin of safety. Nevertheless, there is rarely any occasion to subject the fetus to even this much radiation so early in its development. It is much better to wait until near term, after vital maturation has occurred, before performing such procedures. By doing so the margin of safety is again increased many fold, and maximal value is obtained from the x-ray study as well.

Many authorities contend that the genetic effects of radiation are cumulative. It is held that reproductive cells do not recover from radiation injury but carry the effects on to the next generation. Eventually, by this point of view, unless great caution is exercised sufficient radiation will at length be received by the reproductive cells to effect a genetic mutation or death. This belief has been championed especially by Muller, who has shown (6) rather conclusively that recovery from the genetic effect of radiation does not occur in drosophila. Of course, human beings are not necessarily fruit flies. Anywhere from 3 to 300 r has been claimed to be the amount of radiation necessary to double the spontaneous mutation rate. 80 r is, perhaps, the proper range for this value. To my knowledge no studies are, as yet, available on the offspring of the survivors of Hiroshima and Nagasaki resulting from pregnancies conceived after the bombings. Such would be of real interest.

Kaplan (7) has shown that women who have been treated with small amounts of radiation for sterility have subsequently delivered babies who had no greater tendency to abnormality than babies born of the average female. Of course, if genetic damage by radiation is cumulative detrimental effects may become evident many generations later. It must be remembered that many mutants are not viable. This, in itself, offers some solace when contemplating the social effects of an increased mutation rate on future generations.

It seems logical that some genetic recovery from the effects of radiation must occur, or resistance develop, since many thousand r have been delivered to the earth by cosmic radiation since the dawn of life. Had there been no recovery or development of a resistant strain it is difficult to imagine how any life could persist today. It is certainly better judg-

ment to be as sparing with radiation as possible, consistent with proper diagnostic results, until more reliable information on this subject is available.

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Acute Pancreatitis

EXPERIMENTAL STUDY

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The pathenogenesis of acute pancreatitis has never been clearly elucidated. Even normal physiology of the pancreas is not yet a known, exact science. Experimental and clinical reports emphasizing the "common channel" theory with the resultant reflux of bile under abnormal pressure into the pancreas as the immediate factor involved in the pathenogenesis of pancreatitis, have been presented many times since Opie stimulated thought on this subject some 50 years ago.[1]

Retrograde injections into the pancreatic ducts produce edema of the pancreas by a mechanism previously thought to be entirely the result of interstitial diffusion of pancreatic juices through ruptured ducts. On the other hand, Popper reported that injection of bile or olive oil in varying amounts (0.1 - 3.0 ml.) into the pancreatic duct when the duct was ligated distally, resulted in immediate pancreatic edema without histologic evidence of rupture of the ducts.[2]

Pancreatic edema and necrosis are also produced following the injection of secretin, when the outflow of pancreatic secretion is obstructed.[3] This obstruction may be induced by parasympathetic drugs such as pilocarpine or mecholyl, causing sphincter spasm, or by ligation of the pancreatic duct. Administration of parasympathetic drugs alone over a period of time in dogs and rabbits may be followed by the development of pancreatic edema and focal necrosis. At the present time, the most attractive hypothesis of pathenogenesis which is consistent with experimental observations and results is that duct obstruction occurs as an initial stage and is followed by reflux of biliary material into the pancreatic duct system.[4] Reflux of bile and bile acids under conditions of increased intraductal pressure sufficient to rupture the acinar duct lining permits inter-mixture into the bile of enzymes (trypsinogen and lipase) cellular and tissue juices, and lymph. The resulting chemo-enzymic reaction permits permeation of extra-ductual spaces with a toxic, necrotizing digestive fluid. The chemo-enzymatic product produces in the pancreas and surrounding tissues edema, blood vessel spasm, hemorrhage, cellular and tissue disintegration, partial digestion of devitalized tissue, gangrene, and a sudden demand for calcium to neutralize the fatty acids into calcium soaps. It is now the general feeling that these same mechanisms lead to the pancreatic edema and necrosis noted clinically.

The role of spasm involving pancreatic vessels and its antagonistic measure, namely procaine splanchnic anesthesia, remain to be accurately developed. Since Kuntz holds that all sympathetic fibers to the pancreas end in relation with blood vessels, he feels that secretory and inhibitory effects are exclusively referable to tonic changes in the vascular bed.[5]

Vasodilator fibers have not been demonstrated either in the splanchnic or the vagus nerves. Volume increase in the pancreas measured by plethysmography previously thought due to increased blood flow, is probably due to an increase in interstitial fluid. This in turn follows high pressure developed in the ducts when an actively secreting parenchyma is opposed by a constricted outflow tract.

Method Of Study

In an effort to obtain more objective and rational insight into the role of vasospasm in the production of pancreatitis,

a series of experiments was planned. Retrograde injection of sterile bile was made into the pancreatic ducts of dogs under varying conditions, the ducts being ligated distally in each case to prevent decompression. The acinar rupturing dose of 4 c.c. for ductal injection was chosen since it has been demonstrated that 3 c.c. of bile can be injected into the duct without histological evidence of rupture.[2] It was sought to produce sufficient distention or rupture of ducts to be followed consistently by acute pancreatic edema and necrosis.

Nembutal was used as the anesthetic agent in most of the animals. It was given slowly intravenously until the corneal reflex disappeared. Then the animal was placed on its back, the abdomen shaved, washed with soap and ether, and draped with sterile towels. During the course of surgery, extreme care was employed to prevent blood loss.

A 7 to 8 cm. midline incision was used, which was sufficient to allow delivery of the duodenum thru the incision because of the marked mobility of this organ in the dog. This visualization permitted dissection of the large pancreatic duct and made for easy injection of the sterile gall-bladder bile (dog) into the ducts, the latter procedure being carried out with a 25 gauge needle. Recovery from the effects of the surgery and the experiment was arbitrarily fixed at the point when the dog began to eat voluntarily. The observation was also made that a bowel movement followed soon afterward.

Results

GROUP I - Control Group. Group I consisted of two groups of control animals. Five dogs were operated upon initially, and a second group of five dogs were done at the conclusion of the series. Ligation of the pancreatic duct and retrograde injection of bile was carried out in each of these ten dogs. Immediate development of pancreatic edema was noted at the time of operation in all cases.

In practically every dog, beginning edema was noted at completion of the injection which generally required 15-30 seconds after location, ligation, and needling of the large distal duct. In most instances, within three to five minutes, edema increasing the size of the gland three to six times was noted which did not change further after that time, but free clear fluid was noted later in increasing amounts. The pancreatic lobules were bile stained, and fine radiating green lines could be seen focused around central bile stained areas. The lobules quickly became widely separated with clear edema.

Of this group of 10 dogs, six died, and autopsy on these animals revealed extensive pancreatic necrosis. The remaining four animals had a period of morbidity averaging eight days, before they recovered from the ileus subsequent to the experiments.

GROUP II. Group II consisted of 5 dogs who were handled the same as the control group, except that at the time of surgery, splanchnic block was performed prior to the retrograde injection of bile. The block was accomplished by the retroperitoneal injection of 10 c.c. of 1% procaine hydrochloride solution at the upper pole of each kidney, under direct observation.

Following the block, immediate development of dilated small vessels over the pancreas and duodenum was noted with a change in the color of the lobules from a grey tan to reddish tan hue. Retrograde injection of bile was then carried out as in Group I, with comparable degree of visible edema developing. All dogs in this group survived, the average morbidity being 2.2 days.

GROUP III. Group III consisted of 5 dogs who were treated in the same manner as the control group, except that Etamon was given intramuscularly at the time of the Nembutal anesthesia, in the amount of 25 mgm. per kilogram of body weights, approximately 30 minutes before the injection of bile was made. Some dilatation of the fine vessels over the pancreas developed, though this was not as marked as that seen after procaine splanchnic block. All dogs in this group survived, the average morbidity being 4.4 days.

GROUP IV. Group IV consisted of 5 dogs in whom the pancreatic duct was occluded only long enough to permit retrograde injection to be accomplished, the ligature then being removed. This permitted decompression of the duct system to occur. No splanchnic block was performed. The occurrence of pancreatic edema was not constantly obtained in this group as it was in all other groups. All dogs in this group survived, the average morbidity being 3.6 days.

Discussion

It was noted in the dogs studied, that a diffuse pancreatic network of small red

vessels and a diffuse red lobular undertone developed immediately after the retroperitoneal procaine injection. Though pancreatic edema might be subsequently produced, this network of red dilated vessels persisted, and at no time was evidence of venous stasis noted. This network of red vessels was observed also after intramuscular administration of tetraethylammonium chloride, albeit to a lesser degree, inasmuch as the lobular crimson undertone failed to develop as markedly.

The control animals who received neither procaine splanchnic anesthesia nor tetraethylammonium chloride, with the exception of three animals with an active digestive process, exhibited a dull greyish white lobular appearance to the pancreas, which became even more pale and glassy following injection of bile into the pancreatic duct.

It has been shown that regardless of antecedent happenings, constriction of the arterial vascular bed to the pancreas can be the precipitating mechanism whereby pancreatic edema is converted into pancreatic necrosis.[6] Splanchnic anesthesia is a major immediate adjunct to the control of this disease by increasing blood flow to the gland. Probably secondary effects of this procedure may include decreasing ductal and ampullary spasm to decompress the ductal system, and by blocking vagus stimulation to decrease enzyme levels in external pancreatic secretions. This then might provide a rational background for therapy to be coupled with all other general and supportive measures already routinely employed.

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Experience in the Use of a New Non-Mercurial Oral Diuretic*

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Bowling Green

For a number of years investigators have been seeking an effective diuretic which didn't produce toxic effects. One that could be given orally would be even more desirable. In hopes of finding such an agent Diamox was developed. It is an inhibitor of carbonic anhydrase activity in the renal tubule cells. Such inhibition impairs the secretion of hydrogen ions and diminishes retention of sodium as demonstrated by Pitt and Alexander.[1] Mann and Keilin[2] showed that the sulfonamide compounds were specific carbonic anhydrase inhibitors. Swartz[3] administered sulfanilamide to three patients with congestive heart failure and reported a diuretic effect. Sulfanilamide is too toxic for prolonged or wide-spread usage so that other sulfonamide compounds were tried and led to the discovery of Compound 6063 (2 acetylamino; 1, 3, 4 thiadiazole; 5 sulfonamide) now known as Diamox.[4] Miller,[5] et al, found Compound 6063 to be 50 to 400 times as potent a carbonic anhydrase inhibitor as sulfanilamide. Maren[6] gave extremely large doses of the drug to rodents, dogs and monkeys for long periods without any toxic manifestations. Daily oral doses, 10 times the human equivalent, were given to dogs for a year with no evidence of cumulative toxicity. Single intravenous doses equivalent to 200 times the maximum recommended human dose failed to kill the dogs.

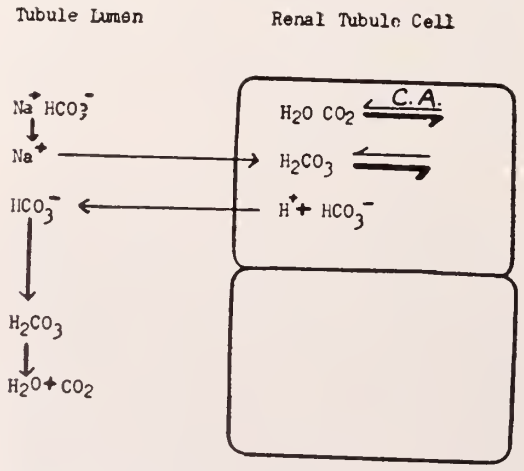
*Read before a meeting of the Sixth Councilor District, June 8, 1954, Bowling Green, Kentucky.

**Medical Section Graves-Gilbert Clinic.

Mechanism Of Action Of Diamox

The sodium ion has long been known to be important in edema and to inhibit its reabsorption in the renal tubules is useful. Carbonic anhydrase mediates the process of urine acidification by accelerating the conversion of carbon dioxide and water to carbonic acid in the tubular cells. The ionization of carbonic acid to form hydrogen ion and bicarbonate ion is thus indirectly dependent on carbonic anhydrase activity. The hydrogen ion so formed takes the place of the sodium ions of

the buffers of the glomerular infiltrate, chiefly in disodium phosphate (NA_2HPO_4) and sodium bicarbonate ($NAHCO_3$). The excretion of sodium acid phosphate (NAH_2PO_4) in the urine conserves sodium which returns to the blood. The carbonic acid formed diffuses back into the blood. The formation of the ammonium ion, which also conserves base by buffering nonvolatile strong acids, is also dependent upon the supply of hydrogen ions. When anhydrase activity is inhibited by Diamox, much less hydrogen ion is available for the acidification process. The sodium ion of the buffers, no longer being replaced by the hydrogen ion, is excreted. Filtered bicarbonate ion, no longer forming carbonic acid in lumen, is also excreted, thus the urine after Diamox administration contains sodium bicarbonate. At the same time lack of hydrogen ion decreases the formation and excretion of ammonium ion. The excretion of potassium ions, when Diamox is given, is caused by a different mechanism which we are not concerned with here. Maren[6] has worked out the cyclic nature of response and recovery following Diamox. These studies show that the loss of base occurs only in the six to twelve hour period following Diamox administration. When low doses are given once a day, as indicated for full diuretic effect, carbonic anhydrase activity begins to return six hours after administration. With resumption of enzyme activity bicarbonate, sodium and potassium ions are retained, and the titratable acidity and the secretion of ammonium increase above the pretreatment levels. In normal dogs there is no net loss of sodium or potassium after the first day of administration of Diamox when given 5 mg. per kilo once a day. It appears that the retention of base during the recovery period compensates for initial base loss. Thus, when given as recommended for diuresis, there should be no distortion of the acid base balance. Although complete and definitive electrolyte data are not yet available for patients with congestive heart failure receiving 5 mg. per kilo a day or every other day, the probable sequence of events may be visualized somewhat as follows. There is certainly a diuresis after the first dose. Loss of sodium and water as evidenced by decrease in edema occur steadily unlike the normal dog on the same dose. The cardiac actually loses sodium mobilized from edema fluid. It is likely that the cardiac excretes urine rich in sodium bicarbonate immediately after Diamox and urine containing considerable ammonium chloride in the drug free interval; thus, the edematous patient receiving Diamox on this schedule loses salt until dry weight is attained and undergoes little change in the acid base balance.



Reproduced through the courtesy of C. K. Friedberg (10)

Clinical Application

Diamox has been administered to hospital and ambulatory patients with congestive failure of varying degrees. Patients with predominently left sided failure may respond well to Diamox without parenteral mercurials. Those with considerable edema, ascites, etc. are best treated initially with parenteral mercurials and once dry weight is attained may often be controlled on Compound 6063. Of course, digitalis, rest, low sodium diets also should be instituted. The optimum dose of Diamox in the edema of cardiac origin is 5 mg. per kilogram body weight or approximately 250 mg. once daily, according to Belsky[7] in studying 33 cases of congestive heart failure of various types. Friedberg, et al,[8] in treating 26 patients with congestive heart failure found that 18 of them demonstrated a diuresis which compared favorably with parenteral mercurial diuretics. It has been stated by several investigators that ammonium chloride should not be given with Diamox because Diamox so used was ineffective. Luckey[9] of Bellevue Hospital stated in a paper at the American College of Physicians meeting in Chicago recently that he had produced excellent diuresis in six patients who were refractory to parenteral mercurials by giving large doses of ammonium chloride and Diamox together. He offered no explanation other than that marked acidification of the urine might

be responsible. Other uses for Diamox which have been suggested are being investigated at the present time. They are nephritis, nephrosis, hepatic cirrhosis, toxemia of pregnancy, emphysema and chronic pulmonary fibrosis with CO_2 retention, and epilepsy. The increased excretion of carbon dioxide in the urine is the basis for usage in pulmonary emphysema. The mild acidosis produced has been given as the reason for reducing the number of seizures in epilepsy.

Side Effects

There have been no serious side effects reported. Careful studies of the kidneys and bone marrow have been made and no deleterious effects have been found. Friedberg, et al,[8] reported drowsiness, paresthesia, lassitude and anorexia but in no case did the drug have to be abandoned because of them. Although Diamox produces a mild acidosis and a loss of sodium and potassium, there have been no reports of difficulty from this; however, this should be kept in mind as a possible complication. Disorientation has been reported when used for cirrhosis of the liver.

Results

Twenty-four patients with congestive heart failure were treated with this drug orally. They were on digitalis and salt poor diets. The degree of congestive failure was mild at the time treated. Some, however, had been quite severely decompensated earlier. We felt that this drug probably would be most valuable in attempting to maintain patients who had reached dry weight or in those whose decompensation was mild. All patients were given 250 mg. each morning initially. The duration of therapy has varied from one week to six months. Eleven patients have received this drug for three months or longer without toxicity. These were all private patients and were treated on an ambulatory basis. There were no controls run on these patients; however, they were not selected except as mentioned above. A good response was one in which the patient was able to reduce the number of shots of parenteral mercurials by half or more. Some were able to leave them off entirely. A fair result was one in which there seemed to be some diuresis but the number of mercurial injections was not materially reduced. A poor result was one in which there was no diuresis.

Diamox was given to patients for several other reasons. Two patients on Cortisone for rheumatoid arthritis received the drug to help control edema. Response was good in both patients. One patient with diabetes and severe intracapillary glomerulosclerosis with hypertension and marked edema got a very good diuresis and lost about thirty pounds. He had paresthesia of the legs while on the medication. One patient with chronic nephritis received no help. Two patients with pulmonary fibrosis, emphysema, and asthma were treated and no improvement that could be stated to come from Compound 6063 could be noted. Ten of these patients were also given a trial on Neohydrin. Five of them preferred Diamox and three thought Neohydrin best. One had no preference, feeling that both drugs were good.

Summary And Conclusions

A brief discussion of Diamox, including pharmacology, clinical evaluation, and toxicity has been presented. Diamox is an effective diuretic administered orally to patients with congestive heart failure. Twenty-four patients with either mild cardiac decompensation or severe decompensation who had reached a dry weight were given Diamox in 250 mg. dosage daily. Nineteen showed good, four fair

Type of Heart Disease	Number Treated	Results	Side Effects	Drug Stopped Because of Side Effects
Arteriosclerotic Heart Disease	18	15 Good 3 Fair 0 Poor	Nausea in three patients	3
Hypertensive Heart Disease	1	1 Good	None	0
Rheumatic Heart Disease	5	3 Good 1 Fair 1 Poor	None	0

and one poor results. It is felt by the author that Diamox is a valuable drug and has a place in the treatment of congestive heart disease of any type. Further investigation may show it to be useful in other diseases.

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Management of Acute Peripheral Nerve Injuries*

Some controversy exists concerning acceptable methods of treatment of acute peripheral nerve injuries of civilian life. The differences of opinion do not stem from any fundamental issue but rather from contrasting approaches to the desirable end-point of the earliest possible nerve suture compatible with maximal anatomical and functional re-innervation. An effort is made in the following notes to present all aspects of the modern management of acute peripheral nerve injury in a dogmatic fashion in keeping with the objectives of this and other bulletins.

I. The first principle of management has to do with the diagnosis or recognition of the fact that a peripheral nerve has been injured. The three major nerves of the upper extremity present unequivocal evidence of dysfunction when severed or when the impact of trauma temporarily depresses axonal conduction. The evidence is as follows:

A. Ulnar nerve. Loss of pain appreciation to sharp pin stimulus over distal two phalanges of the little finger.

B. Median nerve. Loss of pain appreciation over distal phalanges of index or second finger.

C. Radial nerve. Loss of extension of wrist.

In the lower extremity, the components of the sciatic nerve are studied separately; a combination of findings denotes sciatic nerve injury.

D. Peroneal nerve. Loss of dorsal flexion of ankle and toes.

E. Tibial nerve. Loss of plantar flexion of ankle and toes.

A sensory loss over the lateral aspect of the foot is present in tibial nerve injuries below the mid-calf.

Complicated nerve injuries of the brachial and lumbosacral plexuses may be defined by an evaluation of their separate peripheral nerve components. Characteristic hand postures may be noted at the time of acute injury but are not as well defined as they may be when muscle atrophy and shortening have occurred.

II. The second principle of management has to do with the selection of cases for immediate or deferred nerve repair. Cases suitable for immediate repair are:

A. Those seen within the first one to three hours after injury in which infection has not been established.

B. Those not grossly contaminated by highly infective material.

C. Those in which the longitudinal extent of the nerve injury is such that ready suture of the prepared nerve ends may be possible.

D. Those not complicated by severe tendon, bone and vessel injury, threatening the extremity as a whole.

E. Those not complicated by other bodily injuries of immediate and grave prognosis.

In addition to those factors concerning the wound itself:

*This bulletin was prepared especially for the Committee on Trauma, American College of Surgeons, by a special committee of The Harvey Cushing Society. Barnes Woodhall, M. D., Durham, is chairman; Loyal Davis, M. D., Chicago and Henry G. Schwartz, M. D., Saint Louis, are associated with him. Furnished by and published with the permission of the Committee on Trauma of the American College of Surgeons.

A. The surgeon must possess an adequate anatomical background in peripheral nerve anatomy to prevent errors in tissue identification.

B. The patient must be prepared for a tedious and possibly lengthy operative procedure. The presence of acute alcoholism, shock, marked apprehension and the like interdict primary repair. Cases suitable for deferred repair are those failing to meet the criteria noted above. There is scant justification for forcing the issue of primary repair when an elective procedure with its obvious advantages may be substituted for emergency repair within thirty days after injury.

III. The third principle of management has to do with the technique of surgical repair.

A. All wounds causing nerve injury should be treated as noted in "The Care of Hand Injuries IV Lacerated Wounds." Such treatment includes:

1. Thorough cleansing of wound region with soap and water or a bland detergent.

2. Removal of foreign material form the wound.

3. Thorough but conservative excision of devitalized structures.

4. Repeated cleansing of wound by irrigation with warm saline solution.

5. Complete hemostasis.

B. In cases selected for deferred nerve repair, nerve ends should be coapted, if easily identified, with nonabsorbable sutures such as silk or tantalum. In such a coaptation, every effort should be made to prevent the placing of coaptation sutures through normal nerve segments. Deferred nerve repair should be undertaken after primary wound healing or secondary closure has been accomplished. This time period may vary from ten to thirty days after injury.

C. The techniques for immediate or deferred nerve repair are essentially similar. They include:

1. Accurate identification of tissue.

2. Complete removal of pathologic nerve ends to normal appearing fascicles.

3. Accurate apposition of nerve ends with prevention of rotation of nerve segments.

4. Use of interrupted epineural sutures of fine nonabsorbable material, preferably silk or tantalum.

5. Completion of suture without tension. In nerve wounds with considerable —3 cm. or more—loss of nerve substances, suture-line tension must be obviated by joint posturing and by nerve segment mobilization and transplantation procedures.

6. Meticulous care in handling of neural tissue.

7. Placement of single metallic epineural suture 1 cm. from suture-line in distal and proximal nerve segments for postoperative x-ray check of possible suture-line disruptions.

8. Protective casting of extremity, allowing adequate mobilization of metacarpophalangeal and phalangeal articulations, for minimum time period of four weeks.

IV. The fourth principle of management has to do with preservation of the effector mechanism during the prolonged period of re-innervation of muscle. This may be carried out by:

A. Gradual extension of flexed joints through physiotherapy and passive movement beginning when cast is removed.

B. Galvanic stimulation and active massage of paralyzed muscles.

C. Intermittent splinting of paralyzed muscles in a position of functional relaxation.

V. The last principle of management has to do with the care of acute peripheral nerve injury which may be classified as irreparable because of extensive loss of peripheral nerve tissue. Such cases should be referred for orthopedic rehabilitation, as soon as the irreparable nature of the nerve wound is recognized. The potential value of autogenous nerve grafts is recognized; their use requires a specialized experience.

CASE DISCUSSIONS

FROM THE LOUISVILLE GENERAL HOSPITAL

Carcinoma Of The Lung: Late Stage, Simulating Pyogenic Abscess

H.E.L., a 62-year old man, was admitted on November 11, 1951 with complaints of chest pain and a productive cough. For one to two years he had had a cough, productive of gradually increasing thin, mucoid, greenish, occasionally slightly blood-streaked sputum in amounts up to 2-3 cupfuls daily. Three months previously he developed constant dull soreness over the right anterior chest, aggravated by deep breathing and radiating to the right subscapular region. Slight dyspnea, intermittent hoarseness and a 25 to 30 pound weight loss had also occurred over the last three months. Because of the pain he came in for chest x-ray (which had been advised 10 months previously) and he was admitted for further diagnostic studies.

Past History

There had been two previous admissions, the first, August 29 to September 2, 1949, for acute urinary retention due to benign prostatic hypertrophy. Because of chronic hoarseness a laryngoscopy was performed and reported as normal. A chest film was reported as negative for pulmonary disease. He was discharged, to return for a bronchoscopy one week later, but failed to do so. The second admission, December 15, 1950 to January 9, 1951, was for G.I. bleeding, thought due to acute alcoholic gastritis or esophageal varices with cirrhosis of the liver. Esophagoscopy was advised but refused. The chest film made December 15, 1950 is shown in figure number 1. He had enjoyed good health otherwise.

Physical Examination

Temperature 99° F.; Pulse 80; Respiration 22; Blood Pressure 180/105. He was a well developed man, appeared younger than his stated age, coughed frequently, was moderately hoarse, and seemed in good physical condition. The thorax was symmetrical with equal expansion and no noticeable lag on breathing. The lungs were resonant to percussion, but tactile fremitus was increased and the breath sounds were exaggerated over the right upper lung field. Moderately coarse inspiratory and expiratory rales were heard over the right mid-anterior chest. The heart was normal. Abdominal examination showed only a small easily reducible right inguinal hernia. There was no clubbing of the fingers or toes. A small hydrocele was noted on the right and there was moderate enlargement of the prostate.

X-Ray Examination

November 12, 1951 showed the ring-like shadow to be seen in Figure number 2. The differential diagnosis lay between a pyogenic abscess and a carcinoma, the center of which had broken down and been evacuated.

Laboratory Studies

Findings were not significant.

Course In Hospital

Because of inability to obtain a definite diagnosis and because of the possibility of cancer, exploratory thoracotomy

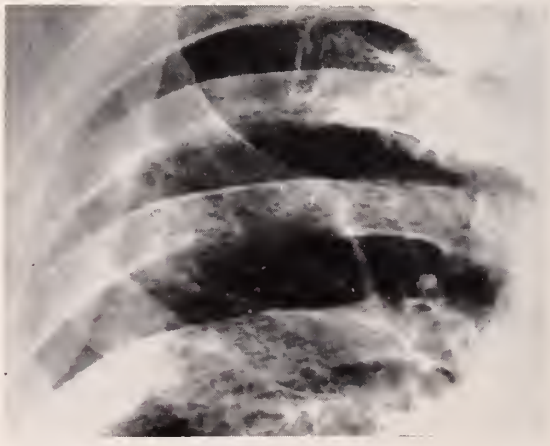


Figure 1. Note the 1cm. rounded, rather sharply circumscribed area of increased density in the right 2nd intercostal space superimposed on the edge of the scapula in this film. From this area of increased density there is an apparent increase in the lymphatics running toward the hilum.

was considered necessary. Bronchoscopy was performed November 13, 1951 and was normal. Exploration of the right chest revealed a 5 cm., irregular, rounded, distinctly hard mass in the upper lobe of the right lung, densely adherent to the anterolateral chest wall. A frozen section of the involved pleura showed squamous cell carcinoma. Although a curative resection was not feasible, a right extrapleural upper lobe lobectomy was performed with the hope of obtaining palliation of his rather distressing symptoms. Pathological study revealed squamous cell carcinoma extending to and through the adjacent parietal pleura into the chest wall with no involvement of the hilar lymph nodes.

His immediate postoperative course was relatively uneventful, but 11 days postoperatively he developed signs of bronchopleural fistula, followed by apical empyema. He was discharged on December 14, 1951 to return for palliative x-ray therapy. Because of continued deterioration he was readmitted on January 3, 1952. X-ray therapy was started January 16, 1952. Thereafter, his course was steadily downhill. Signs of possible cerebral metastases were noted on January 30, 1952, and he expired February 14, 1952.

Discussion

Dr. Herbert T. Ransdell, Jr., Department of Thoracic Surgery: "This patient well illustrates the still too common tragedy of inadequate investigation of a suspicious pulmonary shadow, failure to convince the patient of the necessity of adequate examinations, and delay in exploratory operation. When this abnormality was first apparent in the roentgenogram this man still had a good chance of cure. Procrastination and lack of aggressiveness in study and follow-up allowed this lesion to progress to beyond hope of cure before exploration was undertaken.

Primary carcinoma of the lung is a curable disease when it is diagnosed or suspected sufficiently early—best before symptoms occur—and complete surgical removal is performed without undue delay. Too many unexplained abnormal roentgenographic shadows of the chest are still being disregarded or "sat on" only to turn up later—often several years—as hopeless carcinomas. Unfortunately, the only symptoms are often late signs of cancer, and waiting for them to develop may mean loss of the patient's life.

Our best hope lies in early detection and immediate operative removal of these lesions before symptoms develop. The risk of exploratory thoracotomy today is less than 2 per cent and can now be considered entirely comparable to that of exploratory laparotomy. Grimes (1) recently collected 541 cases from the medical literature of solitary circumscribed lesions in the lungs and found 33 per cent to be malignant. Hood (2), et al, recently reported 156 cases of solitary circumscribed masses in the lung resected with an operative mortality of 1.3 per cent. Two-thirds, or 101, of these lesions could not be accurately diagnosed as to the type of lesion by any means other than thoracotomy and the incidence of malignancies in the explored group was the same as those which could be diagnosed preoperatively.

Carcinoma of the lung is now the leading cancer among men and comprises about 10 to 15 per cent of all cancers in these individuals. It is imperative that all members of our profession keep the possibility of this disease in mind and thoroughly and promptly investigate, by whatever means necessary, any unexplained roentgenographic finding in the thorax regardless of presence or absence of symptoms.

Discussion

Dr. Everett L. Pirkey, Department of Radiology: Widespread use of chest surveys and more frequent use of the chest



Figure 2. Re-examination eleven months later shows a 4 cm. rounded area of increased density which is rather sharply circumscribed and contains a fluid level with air above it. This has the appearance of an abscess, although there is not as much inflammatory reaction around it as is usually seen in the typical pyogenic type of abscess. One must bear in mind, however, that the central part of a carcinoma may become necrotic and be evacuated, as has this one, thus simulating an abscess.

roentgenogram by clinicians have resulted in the findings of chest diseases at earlier stages than has been true in the past. This case is an excellent example of this phenomenon. The original film was interpreted as normal. The patient when seen eleven months later had an obvious abscess in the right upper lobe and on re-examination of the original film the small lesion in Figure 1 was found. It is now believed that this small sharply circumscribed density is a carcinoma in an extremely early stage. However, it is impossible from the film alone to differentiate this lesion from early pulmonary tuberculosis. Also at this stage of development of carcinoma one would not suspect any positive bronchoscopic or sputum findings so that the physician examining this chest is placed in a very difficult situation as regards the differential diagnosis. These rounded circumscribed lesions have been found to represent malignant change in a relatively high percentage of the cases. Those which contain calcium are more frequently either a form of tuberculosis or benign tumors. In the light of our present knowledge, it is thought that a person with a rounded density in the lung such as the one above, even though asymptomatic, should not be observed for any long period of time, but that exploratory thoracotomy should be strongly advised at an early date. We must not wait for the typical appearance of lung cancer or tuberculosis to develop on the roentgenogram before the diagnosis is made and the proper treatment instituted. Cancer is now being seen in the asymptomatic stage but is frequently not being recognized as such. To improve the results of treatment in lung cancer earlier surgery will have to be resorted to and the profession and public must be educated to the fact that it is the asymptomatic case that stands the best chance of cure.

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The J. W. Thompson Memorial Meeting of the Kentucky State Medical Association

Columbia Auditorium, Louisville, Kentucky, September 20, 22, 1954

Digest of Proceedings of the Regular Sessions of the

HOUSE OF DELEGATES

Charles A. Vance, M.D., Lexington, Speaker of the House, presiding

First Session

The first session of the House of Delegates of the Kentucky State Medical Association was called to order by the Speaker, Charles A. Vance, M.D., Monday, September 20, 1954, at 7:15 p.m., at the Columbia Auditorium in Louisville. Glenn Bryant, M. D., Chairman of the Reference Committee on Credentials, reported that a quorum was present. A motion was made that the minutes of the 1953 meeting be accepted as published in the Journal of K.S.M.A. The motion was seconded and carried.

At this time, Bruce Underwood, M. D., Secretary and General Manager, read the names of all Kentucky physicians who had died since the 1953 meeting.

Following are the names of the physicians:

Arnold, Isaac A., Louisville, Dec. 3, 1953
Bach, Luther, Florence, Nov. 28, 1953
Baucom, John E., Winchester, Nov. 6, 1953
Biltz, Robert L., Newport, March 27, 1954
Blood, Hiram I., Hazel Green, Sept. 26, 1953
Bohannon, George H., Louisville, June 21, 1954
Bradley, B. L., Paducah, Jan. 4, 1954
Bristow, Samuel W., Albany, May 11, 1954
Brown, J. Sam, Ghent, July 1, 1954
Buckner, Frank I., Campbellsville, Oct. 13, 1953
Carrick, J. C., Lexington, Sept. 19, 1954
Cash, W. L., Princeton, Jan. 22, 1954
Chandler, Thomas J., Betsey Layne, Nov. 21, 1953
Coblin, R. M., Frankfort, Sept. 11, 1954
Coleman, John C., Lexington, April 20, 1954
Colvin, N. D., Germantown, August, 1954
Coon, George S., Louisville, Dec. 19, 1953
Craddock, James E., Louisville, Dec. 11, 1953
Crouch, M. J., Walton, June 29, 1954
Dalton, J. Rufus, Lexington, Sept. 10, 1953
Duke, John W., Hindman, April 16, 1954
Edwards, Edward E., Irvine, Feb. 22, 1954
Gearheart, Orris, Martin, May 9, 1954
Gibson, William H., Booneville, Sept. 7, 1953
Goodwin, O. P., Pleasureville, May 15, 1954
Hardesty, T. H., Louisville, April 27, 1954
Harrison, Joseph H., Owensboro, May 17, 1954
Hastie, Ilma T., Harlan, Sept. 12, 1954
Hibbitt, C. W., Louisville, Aug. 26, 1954
Hughes, Henry A., McKee, June 19, 1954
Jackson, William H., Louisville, Oct. 7, 1953
Johnson, Curtis B., Earlington, Feb. 20, 1954
Kincheloe, John E., Hardinsburg, June 25, 1954
Kinsey, Russell E., Dry Ridge, March 12, 1954
Lutz, James S., Louisville, July 13, 1954
Lyon, Howard, Winchester, March 28, 1954
Mahaffey, J. A., Richmond, July 15, 1954
Miller, Walter B., Russell Springs, April 20, 1954
Moore, Bankie O., Hopkinsville, Aug.. 15, 1953
Morgan, Edward A., Louisville, Feb. 26, 1954
Mulligun, Louis H., Lexington, Feb. 13, 1954
Nichols, William E., Manchester, Aug. 18, 1954
Nolan, J. W., Harlan, June 15, 1954
Porter, Robert F., Middlesboro, Dec. 31, 1953
Raisbeck, Alden, Lexington, Jan. 6, 1954
Rankin, Fred W., Lexington, May 22, 1954
Reynolds, Charles W., Covington, Aug. 9, 1954
Riley, William E., Harlan, Aug. 19, 1954
Rose, Edward A., Louisville,, Nov. 12, 1953
Rush, William N., Buechel, Nov. 3, 1953
Salyer, Kelson, Jeff, Sept. 9, 1953
Shacklette, John R., Jeffersontown, July 31, 1954
Shawler, Everett F., Louisville, April 6, 1954
Smith, Reuben M., Stearns, Oct. 26, 1953
Sparks, James C., Ashland, June 3, 1954
Stewart, J. D., Owensboro, Feb. 3, 1954
Stone, Eldon W., Bowling Green, July 22, 1954
Thomas, J. J., Middlesboro, Sept. 6, 1953
Thomasson, W. J., Fort Thomas, Sept. 1, 1954
Timmons, J. D., Hanson, May 23, 1954
Travis, D. J., Eddyville, Dec. 21, 1953
Triplett, Henry H., Corbin, June 27, 1954
Turner, Virgil A., Lewisburg, Date Unknown
Victor, Karl N., Louisville, March 9, 1954
Wendell, Thomas T., Lexington, Oct. 4, 1953
Woolery, Kirtley B., Falmouth, March 29, 1954

A moment of silent prayer was observed in their honor.

The Speaker read the list of his appointments for the Reference Committees and the alternate appointments. Motion was made and seconded the appointments for the Reference Committees be approved by the House of Delegates. Motion carried.

Reference Committee appointments are as follows:

Reference Committee No. 1—Reports of Officers and Councilors

E. M. Howard, M. D., Harlan, Chairman
John D. Handley, M. D., Hodgenville, Vice-Chairman
C. F. Long, M. D., Elizabethtown
Wendell V. Lyon, M. D., Ashland
John J. Rolf, M. D., Covington

Reference Committee No. 2—Reports on Medical Care, Medical Education, Hospitals and related subjects

W. Vinson Pierce, M. D., Covington, Chairman

Richard G. Elliott, M. D., Lexington, Vice-Chairman
George Archer, M. D., Prestonsburg
Chris Jackson, M. D., Danville
Garnett J. Sweeney, M. D., Liberty

Reference Committee No. 3—Reports on Legislation and Public Relations

Richard J. Rust, M. D., Newport, Chairman
L. E. Hurt, M.D., Lexington, Vice-Chairman
Carl Fortune, M. D., Lexington
Donald L. Graves, M. D., Frenchburg
Ralph D. Lynn, M. D., Elkton

Reference Committee No. 4—Reports on Miscellaneous Business

T. O. Meredith, M. D., Harrodsburg, Chairman
Wyatt Norvell, M. D., New Castle, Vice-Chairman
Everett H. Baker, M. D., Louisville
Keith Crume, M. D., Bardstown
Karl D. Winter, M.D., Louisville

Reference Committee No. 5—Reports on Miscellaneous Business

Charles B. Stacy, M. D., Pineville, Chairman
Kenneth L. Barnes, M. D., Princeton
Frank Duncan, M. D., Monticello
Roy H. Moore, Jr., M. D., Louisville

Credentials Committee No. 6

Glenn W. Bryant, M. D., Louisville, Chairman
Ralph L. Cash, M. D., Princeton
H. C. Denham, M. D., Maysville

Alternate Committee Members

William E. Becknell, M. D., Manchester
John A. Kincheloe, M.D., Hardinsburg
H. G. Wells, M. D., Georgetown

The following reports of officers were presented at this time and referred by the Speaker to the Reference Committee indicated below:

Report of the President—Reference Committee No. 1
Report of the President-Elect—Reference Committee No. 1
Report of the Speaker—Reference Committee No. 1
Report and Recommendations of the Council—Reference Committee No. 1

J. Farra Van Meter, M. D., Chairman of the Council, reported the Council had voted to nominate E. W. Jackson, M. D., of Paducah, for the Distinguished Service Award. Motion was made and seconded that the Secretary be authorized to cast a ballot for Doctor Jackson. Motion carried.

Doctor Van Meter said the Council had voted to place in nomination for the Outstanding General Practitioner Award the following names: G. W. Freeman, M. D., of Plano; William B. Wallin, M. D., of Brooksville; and R. G. Webb, M. D., of Livingston. After Doctor Van Meter read a brief statement of each nominee's qualifications it was put to vote and Doctor Wallin was awarded the General Practitioner Award.

At this time reports of Officers and Committees were received and referred to Reference Committees as follows:

Report of the Secretary and General Manager—Reference Committee No. 1
Report of the Editor—Reference Committee No. 1
Report of the Treasurer—Reference Committee No. 1
Report of the Delegation to the A. M. A.—Reference Committee No. 1
Committee on Arrangements—Reference Committee No. 1
Committee on Scientific Assembly—Reference Committee No. 1
Public Relations Committee—Reference Committee No. 3
Committee on Medical Service—Reference Committee No. 2
Committee to Study the Constitution and By-laws—Reference Committtee No. 4
Medico-Legal Committee—Reference Committee No. 2
Kentucky Committee for Contributions to American Medical Education Foundation—Reference Committee No. 2
Committee on Cerebral Palsy—Reference Committee No. 2
Committee on Corporate Practice of Medicine—Reference Committee No. 3
Diabetes Committee — Reference Committee No. 2
Dietetic Committee — Reference Committee No. 4
Advisory Committee to the Editor—Reference Committee No. 5
Education Campaign Committee—Reference Committee No. 2
Committee on Emergency Medical Service—Reference Committee No. 4
Committee on Hospitals—Reference Committee No. 2
Insurance Committee—Reference Committee No. 5
Kentucky State Advisory Committee to Selective Service—Reference Committee No. 4
K. S. M. A. Dental Committee—Reference Committee No. 2
K. S. M. A. Pharmacy Committee—Reference Committee No. 5
K. S. M. A. Physicians Placement Committee—Reference Committee No. 2
Legislative Committee—Reference Committee No. 3
McDowell Home Committee—Reference Committee No. 4
Committee on Medical Education—Reference Committee No. 2
Committee to Study Medical Examiner System—Reference Committee No. 5
Medical School Advisory Committee—Reference Committee No. 2
Committee on Nurse Training—Reference Committee No. 2
Professional Relations Committee—Reference Committee No. 4
Committee on Rural Health—Reference Committee No. 4
Committee on School Health—Reference Committee No. 2
Veterans Committee — Reference Committee No. 5
World Medical Association Committee—Reference Committee No. 5
Advisory Committee on Blood Banks—Reference Committee No. 2
Advisory Committee on Cancer—Reference Committee No. 4

Advisory Committee on Crippled Children—Reference Committee No 2
Advisory Committee on General Practice—Reference Committee No. 2
Advisory Committee on Industrial Medicine and Surgery—Reference Committee No. 5
Advisory Committee on Mental Hygiene and Mental Institutions—Reference Committee No. 4
Advisory Committee on Obstetrics—Reference Committee No. 2
Advisory Committee on Pediatrics—Reference Committee No. 2
Advisory Committee on Physical Therapy—Reference Committee No. 5
Advisory Committee on Public Health—Reference Committee No. 4
Advisory Committee on Tuberculosis—Reference Committee No. 5
Advisory Committee to Blue Cross—Reference Committee No. 4
Advisory Committee to United Mine Workers Welfare and Retirement Fund—Reference Committee No. 2
Advisory Committee to Woman's Auxiliary—Reference Committee No. 5
Committee on Scientific Exhibits—Reference Committee No. 4
Committee on Technical Exhibits—Reference Committee No. 5
Report of the Woman's Auxiliary—Reference Committee No. 3
Report of the Board of Directors of the Kentucky Physicians Mutual, Inc.—Reference Committee No. 4
Report on Rural Kentucky Medical Scholarship Fund—Reference Committee No. 2
Report on Medical Research Commission—Reference Committee No. 4
Conference of Presidents and other Officers of State Medical Associations—Reference Committee No. 1
Report of the Member of the Advisory Council to University of Louisville Medical School, Student A. M. A. Chapter—Reference Committee 2

The following new business was presented and referred by the Speaker to the indicated Reference Committee:

Resolution of Fayette County Medical Society concerning dues—Reference Committee No. 5.

Recommendation of Members of the K.S.M.A. for membership on Board of Directors of the Kentucky Physicians' Mutual, Inc.—Reference Committee No. 4.

Resolution on Blue Cross Benefits—Reference Committee No. 4.

The Nominating Committee reported it had placed in nomination the names of G. L. Simpson, M. D., for President-elect; C. C. Johnston, M. D., for eastern Vice-President; Arthur Hurst, M. D., Central Vice-President; Walter L. O'Nan, M. D., western Vice-President; Clark Bailey, M. D., for A.M.A. Delegate; and J. Duffy Hancock, M. D., for alternate A.M.A. Delegate. The Speaker stated the House would elect officers in the second session.

There being no further new business, a motion was made and seconded that the meeting adjourn at 9:20 P. M. Motion carried.

Second Session

The second session of the House of Delegates of the Kentucky State Medical Association was called to order by the Speaker, Charles A. Vance, M. D., Wednesday, September 23, 1954, at 7:15 P.M. The meeting took place at the Columbia Auditorium. Glenn Bryant, M. D., Chairman of the Reference Committee on Credentials, reported that a quorum was present.

J. Farra Van Meter, M. D., Chairman of the Council, presented the final report of the Council, as follows:

This is a supplemental report of the September 20 meeting of the Council of actions so far not reported to the House of Delegates.

The Executive Committee at its February 4 meeting discussed the precedent under which the Editorial Staff of the Journal of K. S. M. A. operated with respect to annual meeting papers. It was pointed out that occasionally papers read before the annual meeting were not appropriate or of such caliber to be published in the Journal of K. S. M. A. The Editor, Bruce Underwood, M. D., said the Advisory Committee to the Editor felt that all papers including those read before the annual meeting should be submitted to the Board of Consultants before being published and that they should not be published automatically. It was moved that this matter be passed to the Council for a decision. After discussing the Executive Committee recommendation the Council voted to give the Editor and the Advisory Committee to the Editor authority to use such annual meeting papers as were appropriate.

It was pointed out at the September 2 meeting of the Executive Committee that the terms of E. M. Howard, M. D., Harlan, and Fred Moberly, M. D., Lexington, who are now serving on the State Board of Health, would expire on December 31, 1954. It was also pointed out that the Kentucky Statutes provide that the State Medical Association nominate three names from which the Governor names one to fill an expiration on the Board. After consideration the Executive Committee voted to recommend to the Council that the same policy regarding the terms of membership for members of the Council of the State Medical Association be put into effect for the members of the State Board of Health and that this would mean that each member of the Board would be limited to two successive terms.

After considerable discussion the Council voted to adopt the recommendation of the Executive Committee.

It was explained to the Council by Doctor Underwood that the term of the Chairman of the Medico-Legal Committee had expired and that it would be the obligation of the new Council to name a successor. It was also explained to the Council that the By-laws Committee was sending to the House of Delegates

a recommendation that the Medico-Legal Committee be abolished and that a Medico-Legal Administrator be appointed to work with the Executive Committee in the handling of medico-legal matters of the members of the Association. It was felt this would streamline and make more efficient this service of the Association to its members. It was agreed that the new Council, when it meets on September 23 at lunch for its reorganization session, should appoint the administrator.

As is customary the Council for the closing year considered the personnel for the various Council-appointed committees to recommend to the new Council for consideration at its reorganization meeting the last day of the annual meeting which will be September 23. These committees which are the Advisory Committee to the Editor, Public Relations Committee, Committee on Medical Service, Education Campaign Committee and Legislative Committee, were recommended.

The Executive Committee recommendation that the Council consider the matter of changing the annual meeting dates within the week from Tuesday, Wednesday, and Thursday to Wednesday, Thursday and Friday was not accepted.

The Council considered the operation of the present section of the By-laws covering Nominating Committees. After discussion it was voted to refer this matter to the Committee on By-laws to study the present method of nominating officers with the view to giving an opportunity for the nomination of more candidates from which officers will be elected by the K. S. M. A. House of Delegates.

Doctor Slucher read correspondence from John B. Allen, M. D., Secretary of the Kentucky Society of Pathologists, relative to the services rendered by Pathologists, X-ray, specialists, and Anesthesiologists. Doctor Slucher also read the resolution offered by the society. Following discussion the Council voted its approval of the resolution submitted by the Kentucky Society of Pathologists, which resolution is as follows:

"WHEREAS: The American system of private practice of medicine has given us the highest health and medical standards in the world;

"WHEREAS, the A. M. A. has publcily declared its stand in favor of this system of private practice; and

"WHEREAS, the practice of pathology including both clinical pathology and anatomic pathology has been regarded as the practice of medicine; and

"WHEREAS, in certain states whose laws concerning the practice of medicine are similar to our own the Attorneys General have officially interpreted the operation of laboratories, x-ray departments and anesthesia departments by corporations such as hospitals as illegal, and acceptance of salaries or commissions from such corporations by licensed practitioners of medicine as unethical fee splitting; and

"WHEREAS, as a result of this interpretation an attempt is being made by certain lay groups to cause revision of the law or its interpretation to permit division of pathology into profession and technical service, the former being personal labor of the pathologist and therefore being the practice of medicine, the latter being the work of the technical assistants (who perform under his direction and supervision) and therefore not the practice of medicine and legally practiced by a hospital; and

"WHEREAS, if this position should be sustained the practice of pathology and thus of all medicine would be in danger of being taken over piece-meal by non-medical personnel and corporations to the detriment of both patient and physician; and

"WHEREAS, as early as 1943 the A. M. A. studied this problem and stated that: 'The House of Delegates of the A. M. A. is opposed to the division of any branch of medical practice into so-called technical and professional factions,' and also that 'the practice of anesthesiology, pathology, physical medicine and radiology are an integral part of the practice of medicine in the same category as the practice of surgery, internal medicine, or any other designated field of medicine.'

THEREFORE, BE IT RESOLVED that the House of Delegates of the Kentucky State Society of Medicine is opposed to the division of any branch of medical practice into so-called technical and professional factions and furthermore instructs its delegates to the A. M. A. to maintain this position."

The necessity for the technicians to make adequate preparations for the presentation of the hour-long television closed circuit program at 5:00 p.m. Thursday was explained to the Council. Following discussion the Council voted to hold the last scientific session of the 1954 meeting in the auditorium upstairs. This is reached by the stairway in the hall near the entrance to the Technical Exhibit Hall.

Gentlemen, this gives you a full report of all actions of your Council during the 1953-54 year.

Respectfully submitted,
J. Farra Van Meter, M. D.
Chairman of the Council

It was pointed out by Doctor Van Meter this resolution submitted by the Kentucky Society of Pathologists was being presented in the second session of the House because the Council had received it only a few hours before this session at its meeting held prior to the House of Delegates session.

The motion was made and seconded that the resolution introduced by the Council be tabled for further study. Motion carried.

At this time the reports of the Reference Committees were presented:

REFERENCE COMMITTEE NO. 1

E. M. Howard, M. D., Chairman

(Reports of Officers and Councilors)

Report of the Preident

(After outlining his various activities during the past year and commenting on the organizational work of the Association the President recommended the following:

1. Support of county, district, state and national medical associations.

2. Development of local talent at district meetings which are a vital, integral part of the medical profession.

3. Selection of one vice president from the part of the state not represented by the President or President-elect to be briefed on associational activities.

4. Appointment of a labor management committee.

5. Improvement of relationship of medical profession with labor groups.

6. Continuation of policy established by the House of Delegates in strengthening the services rendered to the public and to the medical profession and adding to the Association's reserves and solidifying its financial position.

7. Creation of a Press Committee to expedite the improvement of press relations

Reference Committee No. 1 desires to commend President J. Duffy Hancock, M. D., for his competent administration. The fulfillment of this efficient administration entails the loss of many hours from his private practice as well as an extensive travel throughout the state.

President Hancock's recommendations numbers 1, 2, 4, 5, and 6 were approved by the Reference Committee as read. Regarding Doctor Hancock's recommendation number 3, the Reference Committee recommends that the three vice-presidents be continued but that they be invited to Council and Executive Committee meetings.

President Hancock's recommendation number 7 was voted by the Reference Committee to be considered with the recommendation of the Council on the same matter.

The Committee recommends adoption of this section of its report.

Motion was made, seconded and carried that the report of the president be adopted.

Report of the President-Elect

(The president-elect said this year of preceptorship has been valuable in preparation for the coming year. He told of the meetings he had attended, including the June meeting of the American Medical Association. He commented on the splendid example set by the untiring efforts of the president he is to follow.)

The Reference Committee approves the report of the president-elect as read.

Mr. Speaker, I move the adoption of this section of the report.

Motion was seconded and carried that the report of the president-elect be adopted.

Report of the Speaker

(The Speaker expressed his appreciation for the honor of serving as Speaker of the House. He reported he had presided at a special session of the House on April 15, and had made Nominating Committee and Reference Committee appointments. He complimented Hugh L. Houston, M. D., his predecessor, on his work.)

Reference Committee No. 1 approved this report.

Mr. Speaker, I move the adoption of this section of the report.

The motion was seconded and carried that the report of the Speaker be adopted.

Report of the Council

The report of the Council was presented by J. Farra Van Meter, M. D., Chairman.

The 21-page report was a digest of the proceedings of the three Council meetings held prior to the Annual Meeting.

Report Of The Council To The 1954 Session Of The House Of Delegates

FIRST MEETING. The first meeting of the new Council was held September 21, on the last day of the 1953 Council meeting, with Bruce Underwood, M. D., Louisville, Secretary and General Manager of the Association, serving as temporary chairman.

J. Farra Van Meter, M. D., Lexington, was elected Chairman of the 1953-54 Council. B. B. Baughman, M. D., Frankfort, was chosen Vice-chairman, and Dr. Underwood was re-elected General Manager for the Council.

Dr. Van Meter stated that it was customary at this time to elect the five Council-chosen committees for the new year. The committees involved are: (See House of Delegates Manual for personnel.) Recommendations of the 1952-53 Council for these five committees were considered by the new Council individually and all were approved.

It was explained that the By-laws provided the Executive Committee was composed of the Chairman of the Council, who automatically served as Chairman of the Executive Committee; Vice-Chairman of the Council; the President; the President-elect; the Secretary and General Manager; and two members of the Council who are to be elected each year. Hugh Mahaffey, M. D., Richmond, and L. O. Toomey, M. D., Bowling Green, were the councilors elected to serve on the new 1953-54 Executive Committee.

The Council voted to authorize the sending of a letter of appreciation to Hugh L. Houston, M. D., Murray, retiring Speaker of the House, for his splendid work over the past three years.

Dr. Van Meter introduced the new members of the Council, who were elected the night before at the final session of the 1953 House of Delegates. They were: Keith Crume, M. D., Bardstown, Fourth District; J. M. Stevenson, M. D., Brooksville, Ninth District; Garnett J. Sweeney, M. D., Liberty, Twelfth District; Charles B. Johnson, M. D., Russell, Thirteenth District; John Archer, M. D., Prestonsburg, Fourteenth District; and E. W. Jackson, M. D., Paducah, new Vice Speaker of the House.

(Following the precedent set at the September 11, 1952 meeting of the Council, no individual report of the Executive Committee will be made to the House of Delegates. Under this precedent positive action of the Committee will be listed in the Report of the Council and, of course, the recommendations of the Committee to the Council will be noted in the actual

deliberation of the Council. The Executive Committee held five meetings during the 1953-54 year.)

Positive actions taken at the October 29 meeting of the Executive Committee of the Council in Frankfort were:

1. Make no recommendation to the 1954 session of the Legislature to amend the Titles Act.

2. Approved Dr. Underwood's proposal to make the State Board of Chiropody separate from the State Board of Health.

3. Approved in principle certain proposed changes in KRS 211, which relates to the operation of the State Department of Health.

4. Dr. Underwood discussed certain difficulties of operating the State Department of Health under KRS 212 relative to fees covering collections of vital statistics. The Committee voted to leave these changes to the wisdom of the State Department of Health.

5. It was pointed out that the House of Delegates errored editorially by not specifically changing the By-laws when an increase in 1954 annual dues was voted, and that K. S. M. A. attorney, Mr. Vincent Goodlett, had been asked to study the matter. Mr. Goodlett reported that in his opinion the action was legal.

6. J. Duffy Hancock, M. D., K. S. M. A. President, Louisville, was authorized to appoint a committee of K. S. M. A. members, whose purpose it would be to raise funds to be used for the purchase of a bookmobile.

7. It was decided to send the booklet entitled "Science vs. Chiropractic" (which the Council had previously ordered purchased) to every member of the Association after the first of the year, while the Legislature was in session. The appropriate time for this mailing was to be decided by the Legislative Committee.

8. The Committee approved Dr. Underwood's recommendation that Dr. Philip Davidson, President of the University of Louisville, and Mrs. Lois Streuter, Executive Director, Kentucky State Board of Nurse Examiners, should attend the next meeting of the Council.

9. The Executive Committee accepted the recommendation of President-elect Clyde C. Sparks, M. D., Ashland, who discussed the need for the Association to consider the formation of multiple county medical societies. The recommendation was that the Headquarters Office be authorized to contact each councilor for his opinion on the matter and urge him to give his ideas.

10. The Committee considered material presented by the Physicians Mutual which had to do with certain allegations of over-charging the Blue Shield by K. S. M. A. members. The Committee voted "to condemn most strenuously abuses of the Blue Shield program or any other pre-payment insurance and that any complaints be referred back to Blue Shield for filing before being sent to the K. S. M. A. Professional Relations Committee for consideration."

11. The Committee authorized the Chairman of the Medical Service Committee to appoint consultants and recommended that the By-laws Committee consider changes for enlarging the Medical Service Committee.

12. The Committee voted to authorize the expenditure of $150.00 to be used in a vigorous promotion of the candidacy of Joseph I. Greenwell, M. D., New Haven, who was the K. S. M. A. Outstanding General Practitioner Award winner, for the A. M. A. Outstanding General Practitioner Award to be made at the St. Louis meeting in December.

13. The Committee decided to have the 1955 Annual Meeting at the Columbia Auditorium in Louisville. The dates (September 27, 28 and 29) had previously been decided upon.

14. Recommendation of the Technical Exhibits Committee that one-half of the alleged loss of $150.00 by an exhibitor at the 1953 meeting be paid by the Association was refused. It was pointed out that while every possible precaution was taken to safe-guard the exhibitors' goods, the Association could not be responsible for losses.

15. The request of the Times-Journal Publishing Company, Bowling Green, printers of the Journal of the K. S. M. A., for the increase of $1.00 per page, making a total cost per page of $10.00, was allowed since no increase had been allowed during the past three or four years, despite an increase in the cost of labor, supplies, etc.

16. The recommendation of the Committee on Medical Education that the telephone seminar for the 1954 session be discontinued was accepted by the Committee. Reasons advanced were that the programs were too dry and too costly and there was a general lack of interest.

17. Doctor Underwood called the Committee's attention to the House of Delegates' suggestion that the Association contribute $800.00 a year for four years to the Rural Kentucky Medical Scholarship Fund. The Committee voted to continue to consider the matter.

18. The Committee set the next meeting of the Council for December 17.

SECOND MEETING. The Council held its second meeting on December 17 in the office of the Secretary and General Manager, 620 South Third Street. J. Farra Van Meter, M. D., Chairman, introduced the new councilors: John Archer, M. D.; W. Keith Crume, M. D.; Charles B. Johnson, M. D.; and Garnett J. Sweeney, M. D. Doctor Van Meter explained that the fifth councilor, J. M. Stevenson, M. D. was absent due to illness.

1. In the report of the president, Doctor Hancock told of taking part in a half-hour TV show on WAVE the afternoon of December 6, honoring Joseph I. Greenwell, M. D., of New Haven. (Doctor Greenwell won the 1953 K. S. M.A. Outstanding General Practitioner Award and also received the national award given by the A. M. A. for 1953 at the meeting in St. Louis.) Doctor Hancock also listed a multitude of other activities, including county and district meetings he had attended.

2. The report of the delegates to the St. Louis meeting of the A. M. A. early in December was given by Delegate Clark Bailey, M. D., Harlan. Highlights included discussion of the honor Doctor Greenwell has brought Kentucky, and some discussions of important actions taken at the St. Louis meeting. He said that it was voted to support the Bricker Amendment and the Jenkins-Keogh Bill and to oppose extension of the Doctor Draft Act.

3. In the Headquarters Office report

Doctor Underwood mentioned the Greenwell award, described the progress being made by the Journal of the K. S. M. A. by broadening its scientific base, the indigent medical care program, and numerous other activities of the Headquarters Office.

4. Doctor Hancock described the outstanding contribution made by WHAS-TV at the time of the broadcast of the lung cancer operation, along with other activities of the station. The Council then authorized Doctor Hancock to arrange for a suitable award to be presented by Doctor Hancock on behalf of the Association to the station in recognition of this service. The Council also voted to express its deep appreciation to WAVE-TV for its cooperation in broadcasting the half-hour program honoring Doctor Greenwell.

5. Gaithel Simpson, M. D., Greenville, Chairman of the K. S. M. A. Medical Service Committee, reported at length on the survey of indigent medical care that his committee was currently conducting in the state. In addition, he commented on what he felt was the desirability of having Blue Shield increase its benefits to the policyholders, thus making it more salable.

6. Chairman Van Meter announced that the Woman's Auxiliary to the K.S.M.A. would present a new station wagon to the American Cancer Society shortly after noon in the parking lot just south of the main building and all members of the Council were urged to be present. The presentation was made by Mrs. Clyde Sparks, President of the Auxiliary, and was photographed by movie camera for presentation on television news reel.

7. Following luncheon at the Pendennis Club, Chairman Van Meter introduced Doctor Philip Davidson, President of the University of Louisville. Doctor Davidson told the Council that the Universtiy of Louisville was proud of the medical research program being carried on by the University and that more than $1,100,000 had been spent by the University since its inception. He complimented the work being done through the Rural Kentucky Medical Scholarship Fund and stated that 90 per cent of all students are now from Kentucky. He also stated that the University of Louisville was not opposed to the establishment of a second medical school in Kentucky. He expressed the hope that funds would be continued for medical research.

8. The Chairman of the Committee on Medical Education, Lawrence T. Minish, M. D., presented a proposal his committee had drafted for a post-graduate medical education bureau to be established in the Headquarters Office. He stated that qualified physicians would be enlisted from various medical centers in the state to take part in medical seminars, forums or panels and to serve as speakers. Under the plan there would be package programs available which could be called on as needed. One advantage of such a plan is that it would enable participating physicians to prepare their material adequately and in advance. It would also allow the "consumer" to choose the type of program he wanted. The Council voted to accept the recommendation.

9. For the information of the Council, Doctor Underwood then read the action taken by the Executive Committee concerning the proposed revision of the Medical Practice Act, during the 1954 session of the General Assembly. The recommendations include the following points:

(1) The need for some provisions for the continuance of those limited licenses which were issued prior to the passage of the new Medical Practice Act;

(2) The need for a provision to permit the issuance of limited licenses for an indefinite period of time after five years of successful practice;

(3) The need for lowering the requirement of five years to two years for licensure of graduates of American Medical Association approved foreign schools for a regular license;

(4) The need to clarify the matter of the licensure of residents.

10. Doctor Sparks presented the recommendation of the Committee for the Study of Admission of Colored Physicians to K. S. M. A. Membership, of which Joseph C. Bell, M. D., served as chairman. The Council accepted the three-page report, which included, in detail, the developments of the past three years. The report included the following recommendation: That Chapter II, Section 1, of the K. S. M. A. By-laws be amended to read:

> "The Association shall hold an Annual Session and such special session at such times and places as may be determined by the House of Delegates. These sessions shall be limited to the scientific, educational, legislative, economic and business activities of the Association."

In addition, the recommendation included a request that the Council call the House of Delegates of K. S. M. A. into special session for the purpose of setting up a state-wide component for colored physicians, as provided in Chapter XII, Section 1, of the By-laws.

11. Having accepted the recommendations of this committee, the Council voted to call a special session of the House of Delegates to meet in Lexington, Thursday, April 15, at 3:00 p.m., immediately following the County Society Officers Conference.

The Council then adopted a motion calling for no social functions to be sponsored by the Association during the 1954 Annual Meeting. In addition, the Council voted to accept colored medical students in the Student K. S. M. A.

12. Doctor Van Meter explained that certain members of the Fayette County Medical Society felt that the dues had been illegally raised from $25.00 to $35.00 at the 1953 session of the House of Delegates. He stated that the matter had been taken up with the Association's legal advisor, Vincent Goodlett, who had ruled that the procedure followed by the House of Delegates was proper and that the increase in dues by the House was legally consummated.

Doctor Van Meter also read the decision from the Judicial Council of the A. M. A. on this provision, which appeared inconclusive. It was moved, however, that an editorial change be made in the By-Laws changing the dues from $25.00 to $35.00. The motion was seconded and passed that the correction be made.

13. The Council approved the Statement of Organization and Purpose of the Kentucky Council of Allied Medical Services and authorized the Association's participation.

14. The recommendation of the Woman's

Auxiliary to K. S. M. A., made through its President, Mrs. Clyde Sparks, that the Association provide each bookmobile with a subscription to "Today's Health" was approved.

15. There followed a discussion on how to handle non-controversial health legislation during the 1954 session of the General Assembly. The Council voted to leave the setting of policy on these matters with B. B. Baughman, M. D., Chairman of the Legislative Committee, and Dr. Underwood.

16. Doctor Graves called the Council's attention to the fact that the state government had not appropriated any money to provide for the allocation of funds for catastrophic medical services. It was stated that the medical profession could not be expected to provide ample medical services in case of an atomic blast, flood, hurricane or other unforeseen developments, without adequate equipment. The Council voted to support the Civil Defense Committee's suggestion of a minimum amount with which the program could be operated.

17. Doctor Baughman urged the Councilors to be alerted to legislative developments during the coming session of the Legislature and asked for their cooperation in this direction.

Positive actions taken at the February 4 meeting of the Executive Committee of the Council in Frankfort were:

1. In the report of the President, which included some 10 items, Doctor Hancock told of various meetings which he had attended both in and out of the state on behalf of the Association and, as Chairman of the Committee on Scientific Assembly for the 1954 Annual Meeting, reported on developments of the scientific program. He further stated that an outstanding program had been set up for the County Society Officers Conference.

During his report the need for the Association to appoint a Cerebral Palsy Committee and a Dietetic Committee was explained and approved by the Executive Committee.

2. Doctor Underwood, in his Headquarters Office report, told of the growing activity of the Headquarters staff in support of the National Industrial Health Congress to be held the latter part of the month, developments in legislation, plans for the Rural Health Conference, and representation at the A. M. A. Legislative Committee meeting in Atlanta.

3. Following the proposal that the Association consider a group health and accident plan for its members, the Executive Committee voted to reaffirm the stand taken by the Council April 6, 1950, in showing no partiality to any company.

4. The problem of processing and distributing the reports of the officers and committees of the Association to the House of Delegates for the 1954 Annual Meeting was discussed. The Executive Committee voted that every member of the House of Delegates should receive one set of all reports approximately two weeks before the Annual Meeting; that the delegates be requested to bring these reports with them to the meeting, and that a few extra sets be made available to the members of the House of Delegates at the time of the meeting.

5. It was brought to the attention of the Executive Committee by Doctor Underwood that the five year term of the chairman of the Medico-Legal Committee would expire March 17, 1954, and that, according to the By-laws, he would serve until another appointment was made by the Council. After much discussion, it was felt that the Medico-Legal Committee of the Council should operate on the same basis and be appointed in the same manner as other such committees. The Committee voted to refer this matter with these recommendations to the By-laws Committee.

6. In the report of the editor, Doctor Underwood explained that a new section was being planned for the Journal of K. S. M. A. which would be called "Case Discussions" and that Joseph Bell, M. D., had agreed to serve as editor. This new scientific department of the Journal would operate in very much the same manner as that of the New England Journal. Also included in the discussion, was a discussion of the increasing problem of storing K. S. M. A. Journals as time goes along. The staff was authorized to open negotiations with a reliable micro-filming company.

7. Doctor Underwood reported on the meeting that representatives of Fayette and Jefferson Counties held early in the month relative to the problem of medical education in Kentucky and recommended that the Council hold a special session in order to hear both sides of the question as to whether a second medical school should be established. After discussion, it was agreed that the Council would hold a special session following the special meeting of the House of Delegates at the Phoenix Hotel in Lexington, April 15. At this time 40 minutes would be given to each of the following groups to present their views:

(1) Group favoring a medical school in Lexington

(2) Group favoring enlarging the University of Louisville Medical School

(3 Group favoring a medical school in northern Kentucky

(4) Group favoring teaching centers in smaller hospitals

8. The Committee in accordance with KRS 211.040 nominated the following physicians to take the place of the late George S. Coon, M. D., on the State Board of Health: Donald Graves, M. D., Frenchburg; Berhard J. Baute, M. D., Lebanon, and Fred P. Moberly, M. D., Lexington.

9. Doctor Baughman reported on the developments of health legislation in the 1954 Legislature and pointed out that he, Mr. Goodlett and Mr. Miller, the other two being on the scene constantly, were screening all bills introduced into the Legislature in which the K. S. M. A. might have an interest.

10. The Committee heard Mrs. Lois Streuter, President, Kentucky League of Nursing, talk on plans for increasing the educational facilities for nursing. Her recommendations were referred to the K. S. M. A. Committee on Nurse Training.

11. The Committee considered the Cline Report that had been made to the A. M. A. on the osteopathy issue. The Committee instructed the K. S. M. A. delegates to use their best judgment when the matter came up for consideration at the A. M. A. meeting in San Francisco in June.

12. The Committee voted to invite the members of the Board of the Woman's Auxiliary to the County Society Officers Conference

and authorized the State Auxiliary to make such changes in their By-laws as were deemed advisable.

13. A report of the Committee on Medical Service relative to the study of medical indigent care in Kentucky was read by G. L. Simpson M. D., and approved.

14. The recommendations of the Auditor that Workman's Compensation be purchased for the Headquarters Office and that General Premises Liability be purchased for the technical exhibit hall were considered and approved.

Positive actions taken at the April 1 meeting of the Executive Committee of the Council in Louisville were:

1. In the report of the President, Doctor Hancock gave a brief resume of the multitude of activities in which he, as President, had participated. He told of his trip to Indianapolis for a meeting of the state presidents and executive secretaries, and of attending the Second District meeting in Owensboro, and the Southeastern Surgical Conference in Birmingham, at which he was inducted as President. During the meeting of the National Industrial Health Congress he arranged for George F. Lull, M. D., Secretary and General Manager of the A. M. A., to see Mr. Barry Bingham, President of the Louisville Courier-Journal. He reported that Doctor Lull had invited Mr. Bingham or any chosen representative of the paper, to spend as much time as could be spared at the A. M. A. Headquarters Office in Chicago.

2. In the report of the Headquarters Office Doctor Underwood explained that payment of dues of the members was running ahead of any year in the past five. He explained that the Headquarters Office was associated in the promotion of four different Councilor District meetings during the month; that Workman's Compensation and General Premises Liability Insurance, authorized at the last meeting of the Executive Committee, has been purchased and the sale of the technical exhibit space for the Annual Meeting had been absorbed in a very short time. He stated plans for the nomination and support of Clark Bailey, M. D., as Vice President of the A. M. A. were progressing satisfactorily.

3. The first order of business was the presentation of the Budget, discussions and recommendation to the Council. (See report of April 15 meeting of the Council.)

4. Doctor Underwood discussed the results of the legislative effort of the Kentucky State Board of Health during the session just completed. He expressed himself as being pleased that all the bills supported by the department were enacted except one.

5. Doctor Baughman reported on the activities of the K. S. M. A. Legislative Committee. He stated that the Association had been interested in more than 30 bills. He stated that the work of Mr. Vincent Goodlett, Attorney, and Mr. John Guy Miller, Field Secretary for K. S. M. A., in the Legislature was effective. The Executive Committee officially expressed its appreciation to Doctor Baughman.

6. Recommendation of the K. S. M. A. Veterans Committee that the 1954-55 K. S. M. A. contract with the Veterans Administration be renewed this year providing the V. A. would agree to raise the fee schedule to that of the state of Ohio was read. The recommendation was approved.

7. The Committee voted to go on record as approving the fluoridation of drinking water.

THIRD MEETING. The third session of the Council was held as a dinner meeting at the Phoenix Hotel, April 15, following the County Society Officers Conference and the special session of the House of Delegates.

1. As the first item of business, Doctor Toomey, Chairman of the Budget Committee, presented the proposed budget for the 1954-55 fiscal year. Doctor Toomey said that his committee had spent a long day in the Headquarters Office and had carefully considered each item. He explained that the Executive Committee at its April 1 meeting had also gone over the budget and had recommended the acceptance of the budget by the Council. In addition to the budget, the Budget Committee and the Executive Committee recommended the following two items:

(1) The adoption of a retirement plan for employees. The plan would provide for an annuity, which would pay $50 a month at age 65, with the employees paying approximately 60% of the premium and the Association 40%. This plan would be on a voluntary basis. The company offering the plan is the John Hancock Life Insurance Company and the plan is essentially the same as that adopted by the faculty at the University of Louisville.

(2) Due to the increased cost in the operation of an automobile, the Budget Committee recommended to the Executive Committee that the allowance of 7 cents a mile be increased to 8 cents a mile, for car mileage to the President, the President-elect, and members of the Headquarters Office Staff who use their cars in travel on K. S. M. A. business.

After discussion, the Council approved the budget and the two recommendations and expressed its appreciation to Doctor Toomey for his and his committee's efforts.

(Budget appears on page 954.)

2. Doctor Van Meter reported on the special meeting of the Council on the matter of an additional medical school in Kentucky. This meeting was held immediately following the House of Delegates' special session. Following considerable discussion, it was moved "that the Council go on record as to the advisability of furthering medical education in Kentucky and that it should be continued."

3. Carl H. Fortune, M. D., Lexington, Chairman of the Advisory Committee to the United Mine Workers Welfare and Retirement Fund, was introduced and asked to give a recommendation that his committee drafted at an emergency meeting the night before. The following report and resolution was read by Doctor Fortune:

"It has been brought to the attention of the Advisory Committee of the KSMA to the UMWA Welfare and Retirement Fund that an effort is being made by the UMWA Fund officials in Eastern Kentucky to establish a contract form of medicine employing physicians on a salary basis. A special meeting of the committee was held in Lexington on April 14, 1954, at the request of the local medical societies in Pike, Floyd and Johnson Counties, at which a resolution passed by these county societies at a called meeting was presented. Perry County was represented by sev-

APPROVED K. S. M. A. BUDGET FOR FISCAL YEAR

July 1, 1954 - June 30, 1955

ESTIMATED ASSETS AS OF JULY 1, 1954

CASH IN BANKS		$30,400.00	
Checking Account	$ 2,400.00		
Savings Accounts	28,000.00		
INVESTMENTS—AT COST		32,236.52	
U. S. Government Bonds	31,481.00		
Louisville Title Mortgage Company Common Stock	755.52		
ACCOUNTS RECEIVABLE—ADVERTISING		1,300.00	
TOTAL CASH AND INVESTED RESERVES			$ 63,936.52
PROPERTY			4,508.82
Library—Estimated Value		510.00	
Office Equipment—Depreciated Value		3, 998.82	
TOTAL ESTIMATED ASSETS—GENERAL OPERATING AND JOURNAL ACCOUNTS			68,445.34
PROPERTY		44,000.00	
McDowell House—At Appraised Value	25,000.00		
McDowell Home Furnishings—Appraised Value Estimated	19,000.00		
TOTAL ESTIMATED ASSETS—McDOWELL FUND			44,000.00
GRAND TOTAL OF ALL ESTIMATED ASSETS AS OF JULY 1, 1954			$112,445.34

ESTIMATED INCOME AND EXPENSES, JULY 1, 1954 - JUNE 30, 1955

		Estimated Income	Estimated Expenses	
I.	GENERAL OPERATING ACCOUNT	$67,950.00		$62,679.00
	A. Current Fund Expense		$55,809.00	
	B. Officers, Councilors, and Miscellaneous Committee Expense		1,000.00	
	C. Medico-Legal Committee Expense		770.00	
	D. Promotional Expense (Public Relations, Legislative and Education Campaign Committees)		2,000.00	
	E. Medical Service Committee Expense		500.00	
	F. Diabetic Detection Program Expense		100.00	
	G. Post-graduate Education Program Expense		1,000.00	
	H. Annual County Society Officers Conference Expense		500.00	
	I. Rural Health Committee Expense		300.00	
	J. Woman's Auxiliary		500.00	
	K. Physicians Placement Committee Expense		200.00	
	TOTAL GENERAL OPERATING ACCOUNT EXPENSES		($62,679.00)	
II.	JOURNAL ACCOUNT	16,700.00		16,860.00
III.	ANNUAL MEETING ACCOUNT	9,055.00		9,986.00
IV.	McDOWELL FUND ACCOUNT	2,750.00		2,750.00
	TOTAL BUDGETED INCOME	96,455.00		
	TOTAL BUDGETED EXPENSES	92,275.00		(92,275.00)
	GAIN	4,180.00		

eral members, who stated a similar resolution passed by that society at its last regular meeting.

"This resolution, which was unanimously passed by the physicians present at the joint meeting of the three county societies, directed that a committee from these societies meet with the Advisory Committee of KSMA to the UMWA Welfare and Retirement Fund in regard to arranging some satisfactory agreement to be worked out between the physicians and the UMWA Welfare and Retirement Fund. The committee was instructed by the physicians present not to consider any type of salary arrangement but to negotiate on a fee-for-service basis.

"The Advisory Committee after hearing the points of view of the physicians from Eastern Kentucky met and considered this request. We respectfully submit the following resolution for consideration by the Council of K. S. M. A.:

"WHEREAS, the Kentucky State Medical Association by action of its House of Delegates at the 1952 and 1953 sessions, has approved the principle of free choice of physicians and fee-for-service payment of physicians and,

"WHEREAS, it is believed that contract medicine, where fee-for-service practice is possible, is detrimental to the good medical care,

"THEREFORE, BE IT RESOLVED that the Kentucky State Medical Association, acting through its Council, support the physicians in the coal field area in their stand against being forced to accept salaried positions with the UMWA Welfare and Retirement Fund, and

"BE IT FURTHER RESOLVED that the Advisory Committee of KSMA to the UMWA Welfare and Retirement Fund be empowered to act as a negotiating agent to the UMWA Welfare and Retirement Fund and schedule of fees for service submitted by local medical societies, with the understanding that any schedule negotiated shall be referred back to the local medical societies involved for final approval."

After a full discussion the Council unanimously voted to accept the committee's resolution.

The following positive actions were taken by the Executive Committee at its meeting at the Frankfort Country Club on Wednesday, June 2, 1954:

1. The President in his report to the Committee said that plans for the Annual Meeting had been finalized and that the creator of the informational non-comic strip, "Rex Morgan, M. D.," Nicholas P. Dallis, M.D., a psychiatrist of Toledo, would be the speaker at the annual President's Luncheon. He said the dates of the 1956 annual meeting had been set for September 25, 26 and 27, and that confirmations and reservations were on file. He also told of the numerous meetings that he had attended in his capacity as President and gave a list of those that had been scheduled for the future.

2. In the report of the Headquarters Office, Doctor Underwood stated that 1,734 physicians had paid their K. S. M. A. dues, which was well ahead of the 1953 figure. He said the Committee on Medical Service would complete its indigent medical care survey by July 9; that the Education Campaign Committee reported that two more counties had availed themselves of the public relations course for physicians' secretaries and assistants; that the McDowell Foundation had been officially dissolved; and, that reports from advertising in the Journal for the first four months in 1954 show a 26 per cent increase over the same period last year. He stated that the Headquarters Office staff was represented at up to three K. S. M. A. meetings a week, pointed out that at that time there had been no word from the VA relative to reconsidering the Hometown Medical Care contract on the increased fee basis. The Committee voted to authorize the chairman of the Veterans Committee to contact the VA in this connection. And finally, Doctor Underwood suggested that the K. S. M. A. delegation to the A. M. A. meeting in San Francisco be instructed to introduce a resolution to the A. M. A. House of Delegates relative to the passing of Fred Rankin, M. D., Lexington, past A. M. A. President. The Committee authorized this.

3. Complying with KRS, Chapter 16, the Executive Committee nominated three men for each one of the two vacancies on the Hospital Licensure Council, caused by the expiration on June 30 of the terms of C. C. Howard, M. D., and Hershell Murray, M. D. The names of the nominess were: C. C. Howard, M. D., Glasgow; Hershell Murray, M. D., West Liberty; Samuel Flowers, M. D., Middlesboro; Charles Stacy, M. D., Pineville; Hugh L. Houston, M. D., Murray; and Delmas M. Clardy, M. D., Hopkinsville.

4. Daryl P. Harvey, M. D., Glasgow, Chairman of the School Health Committee, appeared and presented the recommendations of his committee that the Second Councilor District be designated as a test area for a program to provide physical examinations for children of school age, under the provisions which his committee had approved. In addition, he recommended that K. S. M. A. attorney, Vincent Goodlett, review the school health statutes. The Executive Committee approved both recommendations.

5. Charles Wood, M. D., Louisville, Chairman of the Emergency Medical Service Committee, appeared and presented the recommendation of his committee that the president of each county medical society be urged to set up an active and alert disaster committee and that the activities of these county units be correlated with the mobile support group activities of the state Civil Defense organization, to render disaster medical care. The recommendation was approved. The recommendation of the Woman's Auxiliary to the K. S. M. A. that one of its members be authorized to work with the Civil Defense Organization was also approved.

6. The Executive Committee approved the proposal of setting up local Public Information Committees in the county medical societies, as presented by Doctor Hancock, and referred the matter to the Public Relations Committee for implementation.

7. Winfrey P. Blackburn, M. D., Frankfort, Chairman of the Committee on Nurse Training, appeared and presented the recommendations of his committee. He said that it was suggested that the Woman's Auxiliary to K. S. M A. cooperate in so far as it was feasible with the program of the Kentucky League of Nursing for the promotion of recruitment of

new students. He also recommended that the State Association join the Kentucky Hospital Association, the Kentucky League of Nursing, and the Kentucky State Association of Registered Nurses in sponsoring the organization of a state joint commission for patient care. The Committee approved both recommendations.

8. The Committee voted that the 1955 County Society Officers Conference be held at Lexington and left the setting of the date to the Headquarters Office.

9. The proposal of the Education Campaign Committee that a "Senior Day" for senior medical students at the University of Louisville School of Medicine be held was considered. It was explained that the Association would offer a full day's program designed to orient doctors and their wives concerning the activities of a private practice of medicine, stressing such things as ethics, the value of organized medicine, the responsibility to render the community a service other than the practice of medicine, and kindred subjects. It was stated that this has been a project of a number of other states for several years and has been felt to be very worthwhile. In other states the day is ended with a dinner and a speech by a strong out-of-state physician. The Executive Committee accepted the proposal that a "Senior Day" be planned, but ruled against asking any drug or commercial houses to sponsor a cocktail party or dinner. If, however, a commercial house offered to provide the dinner or cocktail party that would be another matter.

10. The request of the Henderson County Medical Society for a copy of their charter was read. It was pointed out that the Association's records having to do with charters were stored in the old Board of Health building, at Sixth and Main Streets, and were destroyed by the 1937 flood. The problem of issuing a duplicate charter when the original date of issuance was not known was pointed out. Following discussion, the Committee authorized Doctor Underwood to make a study of this matter and report at the next meeting of the Committee on Thursday, September 2.

Respectfully submitted,
J. Farra Van Meter, M. D.
Chairman of the Council

Reference Committee No. 1 approved the report of the Council as read.

Mr. Speaker, I move the adoption of this section of the report.

Motion was seconded and carried that the report of the Council be adopted.

Council Recommendations.

The three recommendations of the Council to the House of Delegates were:

REFERENCE COMMITTEE REFERRALS

"The Council recommends that the House of Delegates authorize all items relating to the same subject to be referred by the Speaker of the House of Delegates to the same Reference Committee so that two separate Reference Committees will not be considering items which relate to the same subject."

TERMINATION OF EXECUTIVE SESSION POLICY

"The Council recommends to the House of Delegates that the meetings of the House of Delegates be opened to the press and that Executive Sessions of the House of Delegates be held only on special call. The above action does not include the meetings of the Reference Committees."

COMMITTEE ON AWARDS

"The Council recommends that the House of Delegates direct the Speaker of the House to name a committee of five (not necessarily members of the House of Delegates) to serve throughout the year for the purpose of selecting the recipients of the Distinguished Service Award and the Outstanding General Practitioner Award. This appointment shall be made at the final meeting of the House of Delegates and report at the first meeting of the House of Delegates one year later."

Reference Committee No. 1 approves the three recommendations of the Council.

Mr. Speaker, I move the adoption of this section of the report.

The motion was seconded and carried that the three recommendations of the Council be adopted.

Report of the Secretary and General Manager.

(The Secretary and General Manager reviewed briefly the numerous activities engaged in by the Headquarters Office. These include the promotional activities incident to the Annual Health Meeting, the County Society Officers Conference, The Rural Health Conference, preparing the material for the Journal of K. S. M. A., etc.

He pointed out that actually since the Headquarters Office carried out the policies of the Council and Executive Committee and implemented the projects and policies of the other 50 odd committees that the reports of all these committees in the House of Delegates envelope was to a large extent a report of the Headquarters Office activities.

He expressed appreciation of the Headquarters Office for the opportunity of working with the House of Delegates, the Council, the Executive Committee, Officers, and other committees of the Association.)

The report of the Secretary and General Manager was approved by the Reference Committee as read.

Mr. Speaker, I move the adoption of this section of the report.

The motion was seconded and carried that the report of the Secretary and General Manager be adopted.

Report of the Editor.

(Highlighting the Editor's report was the discussion of the popular new "Case Discussion Section," which is edited by Joseph C. Bell, M. D. The Editor expressed his appreciation to Dr. Bell as well as to Jack Chumley, M. D., Louisville, the Associate Scientific Editor, for their excellent work. He also thanked the members of the Board of Consultants as "unsung heroes" for their part in making a better Journal.

The Editor pointed out that advertising revenues during the 1953-54 year had increased by more than 25 per cent. He urged the delegates to support the advertisers and to make constructive criticisms of the Journal.)

This report was approved by Reference Committee No. 1 as a whole.

Mr. Speaker, I move the adoption of this section of the report.

The motion was seconded and carried that the report of the Editor be adopted.

Report of the Treasurer.

(The report of the Treasurer contained the recent audit of the Association's financial situation with statement of financial condition and statement of income and expenses for the fiscal year ending June 30, 1954.)

Reference Committee No. 1 approved the report of the Treasurer.

Mr. Speaker, I move the adoption of this section of the report.

The motion was seconded and carried that the report of the Treasurer be adopted.

Report of the Kentucky Delegation to A. M. A.

(The A. M. A. Delegates reported one of the most enjoyable events of the A. M. A. Clinical Meeting in St. Louis, held December 1-4, 1953, was the presentation by the Kentucky Delegates to the A. M. A. of Joseph I. Greenwell, M. D., of New Haven, Kentucky, to the President of the A. M. A. who presented him to the A. M. A. House of Delegates as the winner of the A. M. A.'s annual award of the Outstanding General Practitioner of the year. One of the delegates, Bruce Underwood, M. D., was chairman of the Reference Committee on Legislation and Public Relations. The A. M. A. Delegates discussed and commented on the effectiveness of the scientific exhibits at this meeting. An added feature, they reported, was a consultation service where physicians could discuss their problems with a group of experts.

The A. M. A. Delegates discussed the actions taken by the House of Delegates at the A. M. A. Annual Meeting in San Francisco, June 21-25, 1954, including fee splitting, the relationship between osteopathy and medicine, medical ethics, veterans' medical care, training of foreign medical graduates, and registration of hospitals. They reported the election of Elmer Hess, M. D., Erie, Pennsylvania, as President-elect for the coming year, and the election of Clark Bailey, M. D., one of the Kentucky Delegates to the A. M. A., as Vice President of the American Medical Association. Doctor Bailey was a member of the Resolutions Committee on the Reports of Officers.)

The Reference Committee approves this report as read. The Committee wishes to recognize the hard work done by the delegates and also recognize with pride the election of Clark Bailey, M. D., as Vice-President of the American Medical Association.

Mr. Speaker, I move the adoption of this section of the report.

The motion was seconded and carried that the report of the Kentucky Delegation to the A.M.A. be adopted.

Report of the Committee on Arrangements.

(The committee reported its work had not been burdensome because of the organization in the Headquarters Office, which takes care of the details necessary to arrange the annual meeting, and said the President's Luncheon had been made a part of the scientific assembly and the Presidential Inaugural Ceremony had been changed from an evening to a day function. The Committee urged the members to avail themselves of the opportunities afforded by the exhibitors, educational movies, and other auxiliary programs.)

Reference Committee No. 1 approves the report of the Committee on Arrangements as submitted.

Mr. Speaker, I move the adoption of this section of the report.

The motion was seconded and carried that the report of the Committee on Arrangements be adopted.

Report of the Committee on Scientific Assembly.

(The report was a digest of the plans for the scientific program of the Annual Meeting.)

The Reference Committee approved the report of the Committee on Scientific Assembly.

Mr. Speaker, I move the adoption of this section of the report.

The motion was seconded and carried that the report of the Committee on Scientific Assembly be approved.

Conference of Presidents and other Officers of State Medical Associations.

(The K. S. M. A. representative, who is on the Executive Committee of the conference, discussed the meeting of the conference which he attended June 20, 1954, in San Francisco.)

The Reference Committee approved the report of the K.S.M.A. Representative to the Conference of Presidents and other Officers of State Medical Associations.

Mr. Speaker, I move the adoption of this section of the report.

The motion was seconded and carried that the report of the Conference of Presidents and other Officers of State Medical Associations be adopted.

Mr. Speaker, I move the adoption of the report of Reference Committee No. 1 as a whole.

Motion was seconded and carried that the report of Reference Committee No. 1 be adopted.

Reference Committee No. 1
E. M. Howard, M. D., Harlan, Chairman
John D. Handley, M. D., Hodgenville, Vice-Chairman
C. F. Long, M. D., Elizabethtown
Wendell V. Lyon, M. D., Ashland
John J. Rolf, M. D., Covington

REFERENCE COMMITTEE NO. 2

W. Vinson Pierce, M. D., Chairman
(Reports on Medical Care, Medical Education, Hospitals and Related Subjects)

Report of Committee on Nurse Training

(Specific points of the report included recommendations to the Executive Committee that it endorse the campaign of the Kentucky League of Nursing to encourage enrollment of more girls in nursing schools and that it approve the formation of a state joint commission for the improvement of patient care.)

The Committee on Nurse Training is to be commended on its excellent work for the year. It was suggested that each K.S.M.A. member be made aware of the part he can give to the nursing education program. Each member should encourage training of both registered and practical nurses and give his personal assistance generally to the procurement and training of nurses.

Mr. Speaker, I move the adoption of this section of the report.

The motion was seconded and carried that the report of the Committee on Nurse Training be adopted.

Report of the Committee on Hospitals.

(Highlights in this report included a discussion of a hospital staff problem and a hospital's admission matter.)

Reference Committee No. 2 recommends that the committee's report be accepted as read. Only two problems arose during the year, and each of them was disposed of in a satisfactory manner.

Mr. Speaker, I move the adoption of this section of the report.

Motion was seconded and carried that the report of the Committee on Hospitals be adopted.

Report of the Committee on Medical Service

(The committee reported the survey on indigent medical care had been completed and the data was being studied. The committee considered Workman's Compensation Laws in Kentucky as related to free choice of physician by injured patient and compensation for total and permanent disability and decided to refer the matter to the Committee on Industrial Medicine and Surgery.)

Reference Committee No. 2 concurs in recommending that further study of the problem of Workman's Compensation Laws in the State of Kentucky as related to free choice of physician be carried out and that this study be referred to the Committee on Industrial Medicine and Surgery.

Mr. Speaker, I move the adoption of this section of the report.

Motion was seconded and carried that the report of the Committee on Medical Service be adopted.

Report of the Advisory Committee on Obstetrics

(No business was referred to the committee for study.)

Reference Committee No. 2 recommends that the report of the Advisory Committee on Obstetrics be accepted as submitted.

Mr. Speaker, I move the adoption of this section of the report.

Motion was seconded and carried that the report of the Advisory Committee on Obstetrics be adopted.

Report of the Committee on Medical Education

(Highlights of the report included the assumption of the committee of the responsibility for the development of the scientific movie program presented at the annual meeting and the formation of a Post-graduate Education Bureau in the Headquarters Office, which is discussed in the Reference Committee report below.)

The Executive Committee of the Council of the Association, at its meeting in Frankfort on October 29, 1953, voted to follow the recommendation of the Committee on Medical Education and discontinued the telephone seminars.

In place of this, a Postgraduate Education Bureau has been established in the Headquarters Office, and a roster of qualified speakers from the membership of the Association has been set up.

Reference Committee No. 2 urges that the facilities of this Bureau be utilized more fully in the future. This Committee also wishes to compliment the Committee on Medical Education for the excellent job which it has done this year in developing the scientific movie program for our 1954 meeting.

Mr. Speaker, I move the adoption of this section of the report.

Motion was seconded and carried that the report of the Committee on Medical Education be adopted.

Report of the Diabetes Committee

(The report discussed the results of the 1953 Diabetes Detection Drive and plans for the 1954 Drive.)

As in previous years, the Diabetes Committee has done an outstanding job in promoting the Diabetes Detection Drive, which was conducted on November 15-21, 1953. In that drive, 35,384 urine sugars were run, and 695 of these were found to be positive.

Under the joint auspices of the Diabetes Committee and the Education Campaign Committee of the K.S.M.A., a Clinitron machine was operated at the Kentucky State Fair recently. Response to this on the part of the public was enthu-

siastic, and it is hoped that this will lend added impetus to the Diabetes Detection Drive for 1954.

Reference Committee No. 2 wishes to compliment the Diabetes Committee on a very excellent report.

Mr. Speaker, I move the adoption of this section of the report.

Motion was seconded and carried that the report of the Diabetes Committee be adopted.

Report of the Member of the Advisory Council to University of Louisville Medical School, Student A. M. A. Chapter

(Delegates from the chapter were sent to the annual convention of the Student American Medical Association in Chicago. Plans are under way to encourage membership in the local chapter.)

The report of the Advisory Committee to the University of Louisville Chapter of the Student A.M.A. points out that there has been a decline in interest and membership among the four classes at the University of Louisville Medical School in the past year.

Plans are under way to encourage membership in the local chapter, and it is hoped that these plans will be fruitful.

Mr. Speaker, I move the adoption of this section of the report.

Motion was seconded and carried that the report of the Member of the Advisory Committee to the University of Louisville Chapter of the Student A.M.A. be adopted.

Report of the Medical School Advisory Committee

(The report stated no meetings were held by the committee during the year; however, included was a report by J. Murray Kinsman, M. D., Dean of the Medical School, concerning the recommendations made by the Committee in 1953.)

Reference Committee No. 2 advises adoption of the Medical School Advisory Committee's report as read and would like to call specific attention of the House to the statement that there were so few well-qualified applicants for admission to medical school this past year that it was not necessary to ask members of this committee to screen the applicant from a personality-evaluation point of view. It is hoped that a larger group of qualified applicants will soon become available.

Mr. Speaker, I move the adoption of this section of the report.

Motion was seconded and carried that the report of the Medical School Advisory Committee be adopted.

Advisory Committee on General Practice

(The report stated the committee was represented by the chairman at a meeting of the Committee on Corporate Practice of Medicine.)

Reference Committee No. 2 recommends adoption of the report of the Advisory Committee on General Practice as submitted.

Mr. Speaker, I move the adoption of this section of the report.

Motion was seconded and carried that the report of the Advisory Committee on General Practice be adopted.

Report of Medico-Legal Committee

(The committee reported professional liability claims in general have increased in Kentucky but the number of malpractice suits remains about the same as previous years. Five cases were carried over from the previous year, six cases were settled out of court by compromise by insurance companies, five cases are still pending and ten cases threatened but no suit brought. No case has come to trial.)

Reference Committee No. 2 wishes to commend the Medico-Legal Committee for its report and would like to particularly draw attention to the fact that not a single malpractice case was tried in Kentucky courts during the past year.

We recommend adoption of this report.

Mr. Speaker, I move the adoption of this section of the report.

Motion was seconded and carried that the report of the Medico-Legal Committee be adopted.

Education Campaign Committee Report

(The report discussed the following projects of the committee: K. S. M. A. News Capsules; public relations course for physicians' secretaries, which has been given in four Kentucky communities; placing A. M. A. prepared radio transcriptions, which have been placed in 27 Kentucky cities; an exhibit at the Kentucky State Fair in conjunction with the Diabetes Committee showing in action the "Clinitron", exhibit at the Kentucky Education Association annual meeting; showing of the motion picture "Your Doctor", and, distribution of A. M. A. pamphlets. The committee pledged its services to assist county medical societies in preparing and presenting medical forums to the public. The committee recommended that the K. S. M. A. pledge its membership to the principle that no person be denied medical care because of his inability to pay for such services, and that the Association's component county medical societies be urged to set up such mechanisms as are necessary to implement this principle, and to so inform the public.)

Reference Committee No. 2 wishes to commend the Education Campaign Committee on its "News Capsules" publication and urge its continuance. We also feel that the television, press and radio releases relative to public health should be encouraged by all members of this Association.

The county society forum approach

to lay teaching seems worthy of expanded effort.

The recommendation that the K.S.M.A. pledge its membership to the principle that no person be denied medical care because of his inability to pay is noteworthy, and Reference Committee No. 2 goes on record as requesting the House of Delegates to take official action approving this principle.

Mr. Speaker, I move the adoption of this section of the report.

Motion was seconded and carried that the report of the Education Campaign Committee be adopted.

Report of the Advisory Committee on Pediatrics

(The committee asked the State Board of Health to liberalize the use of gamma globulin in counties where it was hard for physicians to obtain it for conditions other than poliomyelitis. The report contained two recommendations of the committee which are given in the reference committee report.)

The committee recommends that the Council make a request to the Commissioner of Mental Health that communities now having mental health clinics be maintained, and, wherever possible, the service be expanded.

It was felt important that this committee stimulate and assist any group interested in accident prevention in children and should sponsor a "Child Accident Prevention Week" along with School Health Week in 1955.

Reference Committee No. 2 endorses the recommendations of the committee.

Mr. Speaker, I move the adoption of this section of the report.

Motion was seconded and carried that the report of the Advisory Committee on Pediatrics be adopted.

Report of the Committee on School Health

(The report of the committee is digested in the Reference Committee report below.)

The committee has undertaken a review of the statutes relating to and governing schoool health procedures and practices within the Commonwealth.

An informal survey of the Second Councilor District showed a need for providing all physicians with more information on all phases of the school health problem.

The committee has established a working contact with the Kentucky State Dental Association preliminary to working out a compatible interprofessional position on school health.

The committee recommends that the Committee on School Health should include at least one representative from each K.S.M.A. councilor district to insure proper liaison with the whole profession and that a representative from an appropriate committee of the Kentucky State Dental Association be appointed to the committee. Reference Committee No. 2 concurs with this recommendation.

Mr. Speaker, I move the adoption of this section of the report.

Motion was seconded and carried that the report of the Committee on School Health be adopted.

K. S. M. A. Dental Committee

(The report of the committee is summarized in the Reference Committee report below.)

No matters were referred to the committee this year for action, and no new policies have been proposed in the past twelve months.

A distinguished representative of the dental profession will present a paper in our scientific session, and one of our members presented a paper at the K.S.D.A. meeting in April of this year as an outgrowth of a suggestion made by this committee several years ago.

Mr. Speaker, I move the adoption of this section of the report.

Motion was seconded and carried that the report of the K.S.M.A. Dental Committee be adopted.

Kentucky Committee for Contributions to American Medical Education Foundation

(The chairman attended a meeting of the American Medical Education Foundation from which came the inspiration for the activity discussed in the Reference Committee report.)

In June, 1954, a letter was mailed to all members of the K.S.M.A. relative to contributions to the Foundation. The results of this letter of solicitation are not known, but the committee is assured that Kentucky will make a better showing than in any previous year.

Mr. Speaker, I move the adoption of this section of the report.

Motion was seconded and carried that the report of the Kentucky Committee for Contributions to the American Medical Education Foundation be adopted.

Advisory Committee on Crippled Children

(The report is digested in the Reference Committee report below.)

No matters of business have been referred to the committee for consideration during the past year.

The committee wishes to:

1. Commend the work of the Kentucky Crippled Children's Commission.
2. Mention the Conference on Handi-

capped Children in Kentucky held in Louisville, October, 1953, and a second conference to be held in Lexington, November 11 and 12, 1954.

3. Call attention to a Rehabilitation Center which is about to start operation at facilities in connection with the Louisville General Hospital.

Mr. Speaker, I move the adoption of this section of the report.

Motion was seconded and carried that the report of the Advisory Committee on Crippled Children be adopted.

K. S. M. A. Physicians' Placement Committee

(The report concerned the transfer of the Physicians Placement Service from the State Department of Health to the K. S. M. A. and information on its progress. The three basic principles by which the Service is operated are listed in the Reference Committee report.)

The report of the K.S.M.A. Physicians Placement Committee to the 1954 Session of the House of Delegates was discussed by Reference Committee No. 2, and the three basic principles accepted as its objectives are:

1. The community asking assistance in locating a physician would have to be cleared by the local county medical society secretary or the K.S.M.A. Councilor for the district.

2. That each community must furnish standard information to the service designed to give the prospective physician a clear picture of what to expect.

3. That the physician seeking location must give complete data on his training, background, availability and objectives.

This Physicians Placement Committee is to be commended on its thorough work and activity.

Mr. Speaker, I move the adoption of this section of the report.

Motion was seconded and carried that the report of the K.S.M.A. Physicians Placement Committee be adopted.

Rural Kentucky Medical Scholarship Fund Report

(The report discussed the financial status of the fund and gave information on the recipients of the loans. It was reported that a simplified plan for determining approved locations had been devised and that additional funds must be obtained to continue the program at its present level Many pledges and contributions were received during a campaign to raise funds; however, the total sum is not sufficient to permit assistance of as many students as in the past.)

The report of the Rural Kentucky Medical Scholarship Fund to the 1954 Session of the House of Delegates was read by Reference Committee No. 2 with gratifying satisfaction that it is making progress in offering better medical care for the rural areas of our state. The Fund must have additional money to continue operation, and the contributors are to be commended on their generosity for their donations in 1953 with the hope that this Fund will continue to grow.

Mr. Speaker, I move the adoption of this section of the report.

Motion was seconded and carried that the report of the Rural Kentucky Medical Scholarship Fund be adopted.

Advisory Committee on Blood Banks

(No matters were referred to the committee and therefore no special meetings were called. The committee suggested that the 1955 committee consider the possibility of merging all of the blood banks in Kentucky.)

The report of the Advisory Committee on Blood Banks was read by Reference Committee No. 2. No changes in the report were considered necessary. Reference Committee No. 2 recommends its adoption.

Mr. Speaker, I move the adoption of this section of the report.

Motion was seconded and carried that the report of the Advisory Committee on Blood Banks be adopted.

Report of the Committee on Cerebral Palsy

(The report outlined the functions of the United Cerebral Palsy of Kentucky organization which had been informed of the existence of the committee. The committee made the following recommendations:

1. It is recommended that a medical director be selected by the United Cerebral Palsy Organization and that such doctor be a diplomate or eligible for Specialty Board in the field of either Pediatrics, Neuro-psychiatry, or Orthopedics.

2. Consolidation of the various cerebral palsy clinics in the state under one management.

3. The committee commends the spirit in which the Cerebral Palsy Commission of Kentucky has organized its group for the care of these children and that the criticizing and evaluation of the efficiency and the worthwhileness of the organization will depend upon further analyzation of their specific program as it meets the needs of the children presented there.)

The report of the Committee on Cerebral Palsy was read and discussed at length by Reference Committee No. 2. It is the opinion of Reference Committee No. 2 that this subject requires more study and that no definite recommendation can be made at the present time.

Mr. Speaker, I move the adoption of this section of the report.

Motion was seconded and carried that

the report of the Committee on Celebral Palsy be adopted.

Mr. Speaker, I move the adoption of the report of Reference Committee No. 2 as a whole.

Motion was seconded and carried that the report of Reference Committee No. 2 be adopted.

REFERENCE COMMITTEE NO. 2

W. Vinson Pierce, M. D., Covington, Chairman

Richard G. Elliott, M. D., Lexington, Vice-Chairman

Garnett J. Sweeney, M. D., Liberty

Chris Jackson, M. D., Danville

George Archer, M. D., Prestonsburg

REFERENCE COMMITTEE NO. 3

Richard J. Rust, M. D., Chairman

(Reports on Legislation and Public Relations)

Report of the Public Relations Committee

(No formal meetings of the entire committee were held; however, members of the committee attended several meetings which were of interest to the members of the Association. Several conferences were held with the executive secretary of the Association at which various pamphlets regarding public relations were reviewed with the idea of drawing up similar pamphlets to be distributed to members of our Association.)

It was recommended that this report be received by the House of Delegates with thanks and filed.

Mr. Speaker, I move the adoption of this section of the report.

Motion was seconded and carried that the report of the Public Relations Committee be adopted.

Report of the Woman's Auxiliary

(The Auxiliary reported its total membership is 922, including 64 members-at-large, which is an increase of 68 members over last year's total, and Mrs. Clark Bailey, one of Kentucky's past presidents, was elected 4th Vice President of the Auxiliary to the American Medical Association. The report included highlights of other activities of the Auxiliary.)

It was felt by this Reference Committee that this report of the Woman's Auxiliary be received with sincere thanks to the president of the Auxiliary and all of the officers, committee chairmen and members stating the excellent work which they have done in the past year. It is felt advisable to inform the House of Delegates of the numerous ramifications of the work of the Auxiliary and of the diversity of the projects which they have undertaken. Among the projects which they have undertaken and in which they have participated in conjunction with other groups are cancer societies, civil defense, heart and tuberculosis, the problems of mental health in Kentucky, nurse recruitment and public relations. They have, moreover, been doing splendid work in the McDowell project and in rural health. It is felt that this House of Delegates should compliment the Woman's Auxiliary in its splendid work and express a desire that this work continue in the same noble fashion.

Mr. Speaker, I move the adoption of this section of the report.

Motion was seconded and carried that the report of the Woman's Auxiliary be adopted.

Report of the Committee on Corporate Practice of Medicine

(The report concerned the problems related to the corporate practice of medicine. The committee proposed that fee schedules be set up on a local level which any group desiring to purchase medical care and urged each county medical society to put into action its machinery for dealing with the corporate practice of medicine on a local level.)

The report of your Committee on Corporate Practice of Medicine was reviewed at length by this Reference Committee. The importance of consideration of corporate practice in Kentucky cannot be stressed too highly. Your Reference Committee feels that the report of this committee should be accepted with sincere thanks for the great amount of effort and thought which this committee has given to this work.

There is one point of clarification of the committee report which was discussed with the chairman of the committee, Clark Bailey, M. D. This is the third paragraph of the report which you have in your folders. As it is written it may possibly be construed as requiring local medical societies to set up fee schedules for any group desiring to purchase medical care. According to the chairman of the committee, Doctor Bailey, it was the intention of the committee that any setting up of fee schedules which was felt advisable by the local group is to be done on a local level rather than by any higher echelon. This is entirely on a voluntary basis and is in no sense to be construed as compulsory in any way, shape, or form.

It was also felt advisable by your Reference Committee that the following considerations be taken up by the new Committee on the Corporate Practice of Medicine: (1) A concise, clear, comprehensive definition of the corporate practice of medicine be given. (2) The status determined of certain groups of the medical profession commonly employed by hospitals, namely; radiologists, pathologists, anesthesiologists, and neuropsychi-

atrists, relative to the corporate practice. (3) The status determined of the physician employed by lay-sponsored groups relative to this practice.

Mr. Speaker, I move the adoption of this section of the report.

Motion was seconded and carried that the report of the Committee on Corporate Practice of Medicine be adopted.

Report of the Advisory Committee on United Mine Workers Health and Welfare Fund and Supplemental Report

(Highlights of the report were discussions of the numerous meetings of the committee, resolution on the principle of free choice of physician and fee-for-service payment of physicians, and recommendations of the committee.)

Your Reference Committee recommends to the House of Delegates that it extend its heartfelt thanks for the unstinting and untiring efforts of this committee in its most difficult job. Throughout the year numerous meetings were held by this committee and the other interested groups and much effort was made and many disappointments were met by this committee.

The following recommendations of the Advisory Committee to the U.M.W.A. Retirement Fund are presented for your consideration:

(1) That this House of Delegates approve in its entirety the following committee-recommended resolution:

WHEREAS, the Kentucky State Medical Association by action of its House of Delegates at the 1952 and 1953 sessions has approved the principle of free choice of physician and fee-for-service payment of physicians; and

WHEREAS, it is believed that contract medicine where fee-for-service practice is possible, is detrimental to good medical care;

THEREFORE, BE IT RESOLVED that the Kentucky State Medical Association, acting through its Council, support the physicians in the coal field area in their stand against being forced to accept salaried positions with the UMWA Welfare and Retirement Fund, and

BE IT FURTHER RESOLVED that the Advisory Committee of KSMA to the UMWA Welfare and Retirement Fund be empowered to act as a negotiating agent in presenting to the UMWA Welfare and Retirement Fund any schedule of fees for service submitted by local medical societies, with the understanding that any schedule negotiated shall be referred back to the local medical societies involved for final approval.

Mr. Speaker, I move the adoption of this section of the report.

Motion was seconded and carried that the resolution of the Advisory Committee to the UMWA be adopted.

(2) At the 1953 session, the House of Delegates endorsed a recommendation of this committee that the Committee on Hospitals be requested to set up an advisory service to aid smaller hospitals which wished to improve standards. Such an advisory service would likely require cooperation of the Kentucky Hospital Association. The committee feels this need still exists and urges further study and action at an early date.

Mr. Speaker, I move the adoption of this section of the report.

Motion was seconded and carried that the recommendation be adopted.

(3) It is urged that the Kentucky State Medical Association give careful consideration to the following problems which have presented themselves during this past year:

a. What attitude shall be adopted toward the employment of salaried physicians by health programs which, even though under medical direction, are lay-sponsored?

b. Should the K.S.M.A. or any of its agencies undertake to negotiate fee schedules for physicians caring for beneficiaries of health programs?

c. What responsibility should the K.S.M.A. or any of its committees take in the establishing of medical audit and tissue committees in smaller hospitals or groups of hospitals?

d. Should any committee of the K.S.M.A. allow itself to be drawn into controversies involving the competence of individual physicians or the adequacy of hospitals' facilities?

Mr. Speaker, I move the adoption of this section of the report and that the problems herein stated be referred by this House to the appropriate committees appointed for the next year.

Motion was seconded and carried.

(4) It is urged that a study be made during the next year of the whole problem of the relation of the K.S.M.A. to lay-sponsored health and welfare programs and that such a study be immediately undertaken by an appropriate committee.

Mr. Speaker, I move the adoption of this section of the report.

Motion was seconded and carried that this section of the report be adopted.

Report of the Legislative Committee

(The report covered the committee's activities during the General Assembly which met in January and is digested by the Reference Committee.)

The Reference Committee has studied the report of the Legislative Committee and wishes to compliment it on having had a very busy and successful year. More than thirty bills have been considered by the 1954 session of the Kentucky General Assembly, which affected adversely or favorably the medical profession and the health of the people it serves. Among the measures enacted into law were proposals related to tuberculosis control, rabies control, the Rural Kentucky Medical Scholarship Fund, creation of a Board of Ophthalmic Dispensers, regulation of the practices of optometry, and liberalization of the statutes governing chiropody, all of which had, as passed, the support of the medical profession. Other bills passed included an amendment to the statutes to enable city universities to spend profits of bond issues for their law, medical, and dental schools; a provision that a prescribed percentage of alcohol in the defendant's blood shall give presumption of guilt; the amendment to the statutes to put coroners on monthly compensation; designation of county health officers or administrators as registrars of vital statistics; amendment of the statutes to establish tuberculosis districts and redesignating the Tuberculosis Sanitoria Commission as the State Tuberculosis Hospital Commission; amendment of the statutes transferring to the Department of Health those functions of the State Board of Health which are administrative in nature and clarified other statutory provisions; the amendment of the statutes to define certain synthetic habit forming drugs as narcotics and repealing certain conflicting sections of the Narcotics Act regarding marijuana.

Due to the alertness of your committee certain "sleeper proposals" which had been incorporated in certain bills were discovered and eliminated. On a national level your committee, in conjunction with other state committees in the American Medical Association, was able, at least for the present, to prevent the passage of compulsory participation in the Social Security Act. At the present time the efforts of this group are directed toward defeating the re-insurance bill, resulting in a vote by the House of Representatives, by a good majority, to re-commit this bill, despite the vigorous objections of the President and Mrs. Oveta Culp Hobby.

Mr. Speaker, I move the adoption of this section of the report.

Motion was seconded and carried that the report of the Legislative Committee be adopted.

Mr. Speaker, I move the adoption of this report as a whole.

Motion was seconded and carried that the report of Reference Committee No. 3 be adopted.

REFERENCE COMMITTEE NO. 3

Richard J. Rust, M. D., Newport, Chairman

L. E. Hurt, M. D., Lexington
Carl Fortune, M. D., Lexington
Ralph D. Lynn, M. D., Elkton
Donald L. Graves, M. D., Frenchburg

REFERENCE COMMITTEE NO. 4

T. O. Meredith, M. D., Chairman

(Reports on Miscellaneous Business)

Report of Committee to Study Constitution and By-laws

This requires the action of the House on each article, so the report will be read in full and each article voted on separately by the House of Delegates in order that it meet the requirements of the legal adviser, Mr. Vincent Goodlett, of Frankfort.

Amended Report of Reference Committee No. 4 on the Report of the Committee to Study Constitution and By-laws

The present Constitution states in Article XII. Amendments:

"The House of Delegates may amend any article of this Constitution by a two-thirds vote of the delegates registered at that Annual Session, provided that such amendment shall have been presented in open meeting at the previous Annual Session, and that it shall have been sent officially to each component county society at least two months before the session at which final action is to be taken."

This being the case and these recommended changes in the Constitution not having been delivered to the component societies for their study two months prior to the Annual Meeting cannot now be voted upon. This does not apply to the changes in the By-laws but inasmuch as some of the changes in the By-laws are contingent on the changing of the Constitution, this committee recommends that the report of this Committee to study the Constitution and By-laws be adopted as a report only and referred to each component society for their study and recommendation and be brought back to the House of Delegates at its next annual session. This committee recommends the adoption of this report.

Motion was made, seconded and carried that this report be adopted.

Report of the K. S. M. A. Dietetic Committee

(The report concerned the standardization of diets for all hospitals in the state and plans for a cooperative weight control program.)

This report deals with standardizing diets for all hospitals in the state, which would be particularly beneficial to small hospitals, and this committee feels that this would be beneficial to all rural community hospitals.

Mr. Speaker, I move the adoption of this section of the report.

Motion was seconded and carried that the report of the Dietetic Committee be adopted.

Report of the Committee on Emergency Medical Service

(The committee urged the members of the Association to cooperate with the Civil Defense Agencies and to plan and prepare on a local level for civilian disasters.)

The Reference Committee feels that additional emphasis should be placed on the following statement: "We feel that each community should have such a plan available to put into operation if a disaster occurs, and we urge the members of the medical profession on the local level to make such plans as may be necessary so that prompt, efficient care may be rendered to victims of whatever disaster might occur."

Mr. Speaker, I move the adoption of this section of the report.

Motion was seconded and carried that the report of the Committee on Emergency Medical Service be adopted.

Report of the Kentucky State Advisory Committee to Selective Service

(The report discussed the activities of the committee and stated that during the past few months the tempo of call for medical and dental personnel has been stepped up. It was reported a fairly large call is anticipated in December.)

The Reference Committee feels that due consideration should be given to deferment of essential men from remote, rural areas. The Reference Committee wishes to commend the Advisory Committee to Selective Service for their work in cooperation with all the physicians in Kentucky.

Mr. Speaker, I move the adoption of this section of the report.

Motion was seconded and carried that the report of the Kentucky State Advisory Committee to Selective Service be adopted.

Report of the McDowell Home Committee and Supplemental Report

(The report discussed the dissolution of the McDowell Memorial Foundation, Inc., financial status, maintenance, and furnishings of the McDowell Home, and plans for tearing down the Apothecary Shop.)

This report deals with the furnishing of the McDowell Home in Danville, its operation and its financial condition. The committee feels that this is an important problem and recommends a further study with the view of being able to properly maintain and operate the McDowell Home with as little cost as possible to the State Medical Association. We wish to call attention of the House to the fact that in the past year $1,500 was donated by the State Medical Association and $1,000 by the Kentucky Surgical Association for the upkeep and maintenance of the house. The report recommends that this donation be continued for another year.

Mr. Speaker, I move the adoption of this section of the report and of the supplemental report, as submitted.

Motion was seconded and carried that the report and supplemental report of the McDowell Home Committee be adopted.

Report of the Professional Relations Committee

(The committee considered fourteen cases in which charges had been brought against members of the Association, the majority of these being complaints of overcharge. The report elaborated on a case of an insurance company against a physician for charging to fill out lengthy blanks.)

This report deals with complaints against physicians that were submitted during the year 1953-54. It deals in part with fees which we feel the insurance companies should pay for lengthy and involved medical reports.

Mr. Speaker, I move the adoption of this section of the report.

Motion was seconded and carried that the report of the Professional Relations Committee be adopted.

Report of the Committee on Rural Health

(The committee reported on the progress of the Kentucky Rural Health Movement, Rural Health Council, Third Annual Rural Health Conference, and the appointment of a Rural Health Committee by the Woman's Auxiliary. The committee recommended that a simple statement of purpose of the Kentucky Rural Health Council be prepared as the only article of organization required for proper functioning of the council and recommended that the size of the K. S. M. A. Rural Health Committee be reduced to eight interested and active members.)

Reference Committee No. 4 recommends the adoption of this report as sub-

mitted, with emphasis being placed on the following statements: "Each member of the Kentucky State Medical Association should recommend to his rural citizens that a Rural Health Council be formed and then give whole-hearted support to the projects and activities of the council."

Mr. Speaker, I move the adoption of this section of the report.

Motion was seconded and carried that the report of the Committee on Rural Health be adopted.

Report of the Advisory Committee on Mental Hygiene and Mental Institutions

(Reference Committee Number 4 chairman explained to the House that the Committee felt this report was so important he asked permission to read it. High points of the report included the following:

(1) The desirability of deleting outdated terms describing the mentally ill (2) Clarifying the jurisdiction of the Department of Mental Health and the Department of Welfare (3) Extending the duration of the Health Officer's Admission procedure from ten days to fifteen days to allow adequate time for observation and examination of the patient;

(4) To streamline the revisions concerning payment for patients' board (5) Discussion of the bill to revise Chapter 210 of the Kentucky Revised Statutes (6) The development of a family care program for patients of state mental hospitals (7) Provision for the keeping of patient records in confidence (8) Provision for the utilization of printing facilities.

Improved conditions in state hospitals were noted and the statement was made, "for the first time in many years every position of professional status is filled."

A practical nurse school is being started at Kentucky State Hospital, Danville, while patients with tuberculosis are being centralized in Lexington.

It was pointed out that the Commissioner on Mental Health needed more funds to carry out long range programs—Copies of report on file at Headquarters Office, K. S. M. A., for all who might wish one.)

We wish further to commend the 1954 Legislature for its splendid contribution to the improvement of mental health in Kentucky, and we further recommend that each county medical society thoroughly familiarize itself with this report, and that each commend its local representatives on the work they did in securing this legislation. We wish also to commend our Commissioner of Mental Health, Frank Gaines, M. D., for his untiring work in the modernization of our mental health law. We further wish to commend the Advisory Committee on Mental Hygiene and Mental Institutions on its splendid work.

Mr. Speaker, I move the adoption of this section of the report.

Motion was seconded and carried that the report of the Advisory Committee on Mental Hygiene and Mental Institutions be adopted.

Report of the Advisory Committee on Public Health

(The committee recommended that "Immunization Week" be repeated annually. The committee and representatives of the Kentucky State Department of Education and representatives of other interested groups, after meeting together, requested the State Superintendent of Public Instruction to ask the Governor to appoint an advisory committee to the State Department of Public Instruction for the development of a compulsory accident prevention training program in the schools with television instruction as a part thereof. The committee recommended to the House of Delegates that it give its approval of the plan for an advisory committee and full K. S. M. A. participation in the accident prevention training program.)

This report deals with the problem of injuries and accidental deaths among the young people of Kentucky and also with the immunization program that was conducted in May. We wish to emphasize that this problem of accidental injuries is becoming more serious throughout the state, and we commend the committee on its work in bringing this to the attention of the Kentucky State Department of Education by recommending that compulsory accident prevention training be set up in the public schools.

Mr. Speaker, I move the adoption of this section of the report.

Motion was seconded and carried that the report of the Advisory Committee on Public Health be adopted.

Report of the Committee on Scientific Exhibits

(The report concerned the selection of scientific exhibits submitted for display at the annual meeting.)

Mr. Speaker, I move the adoption of this section of the report.

Motion was seconded and carried that the report of the Committee on Scientific Exhibits be adopted.

Report of the Advisory Committee on Cancer

(The chairman attended several meetings of a group which represented the State Board of Health and a group which represented the Cancer Society, the purpose of these meetings being to arrange for proper distribution of funds available between the American Cancer Society and the U. S. Public Health Service.)

Mr. Speaker, I move the adoption of this section of the report.

Motion was seconded and carried that the report of the Advisory Committee on cancer be adopted.

Report of the Medical Research Commission

(A booklet, "Report of Progress," was prepared by the University of Louisville School

of Medicine which presented a report of all research performed by the School since 1948 which was sponsored by the Commission and also contained a financial report of how the Medical Research Commission grant was used to defray medical research expenses. The 1954 General Assembly increased appropriations to the Commission to $300,000.00 for each year of the current legislative biennium.)

This report deals with the appropriation of money by the Legislature for use in the medical research program.

Mr. Speaker, I move the adoption of this section of the report.

Motion was seconded and carried that the report of the Medical Research Commission be adopted.

Report of the Advisory Committee on Blue Cross

(The chairman has been in contact with the officers of the Blue Cross and has offered suggestions regarding the operation of the plan. Progress has been made in regard to enlargement of membership and increasing the services of this organization.)

Mr. Speaker, I move the adoption of this section of the report.

Motion was seconded and carried that the report of the Advisory Committee to Blue Cross be adopted.

Report of the Board of Directors, Kentucky Physicians Mutual, Inc.

(The report discussed the financial condition and growth of Kentucky Physicians Mutual, Inc., and the broadened schedule of indemnities. The Mutual has successfully completed its fifth year of operation.)

This is the report of the Kentucky Physicians Mutual for the year ending July 31, 1954. We would like to call the attention of the House of Delegates to the fact that this is your insurance plan and we wish to elicit the support of every Kentucky physician and welcome the criticisms and suggestions that you may make. It is interesting to note that since the inception of this plan five years ago we have paid to the physicians of Kentucky in benefits to subscribers a total of $3,399,870.35, of which $1,529,699.10 was paid in the last fiscal year. We have grown from no subscribers on August 1, 1949, to 95,904 contracts, representing 249,350 participants as of July 31, 1954. It is the duty of the House of Delegates to submit eleven names to the Board of Directors of the Kentucky Physicians Mutual to fill the places of the seven members whose terms will expire in October of this year. Mr. Speaker, the Reference Committee wishes to commend the members of the Kentucky Physicians Mutual, Inc. for the excellence of their work.

Mr. Speaker, I move the adoption of this section of the report.

Motion was seconded and carried that the report of the Board of Directors of the Kentucky Physicians Mutual, Inc. be adopted.

Recommendation of Members of K. S. M. A. for Membership on Board of Directors of the Kentucky Physicians Mutual, Inc.

The House of Delegates on Monday night, September 20, recommended the following names to be submitted to the Kentucky Physicians Mutual:

Richard Rust, M. D., Newport
J. Duffy Hancock, M. D., Louisville
Coleman C. Johnston, M. D., Lexington
John Dickinson, M. D., Glasgow
Thomas O. Meredith, M. D., Harrodsburg
Clark Bailey, M. D., Harlan
Joseph C. Bell, M. D., Louisville
W. H. Barnard, M. D., Elizabethtown
K. D. Leatherman, M. D., Louisville
Thomas Milton, M. D., Owensboro
Glenn U. Dorroh, M. D., Lexington

Mr. Speaker, I move that these names be submitted to the Kentucky Physicians Mutual, Inc.

Motion was seconded and carried.

Resolution on Blue Cross Benefits

Mr. Speaker, we have a resolution on Blue Cross benefits. This resolution reads as follows:

WHEREAS, Blue Cross hospitalization insurance plans are usually limited by their corporate laws to pay benefits to hospitals only; and;

WHEREAS, it appears desirable from both an economic and public service aspect that such plans should pay benefits in emergency cases for use of office facilities and supplies to a physician; and

WHEREAS, emergency medical service does not always need to be rendered in a hospital, but a subscriber to Blue Cross must receive such treatment in a hospital in order to receive the benefits; and

WHEREAS, in many areas additional costs are incurred transporting the patients to the hospital when the emergency care could more properly and efficiently be rendered in a physician's office; and

WHEREAS, Revisions in the Blue Cross policy to provide payment to physicians for use of their own office facilities, equipment, and supplies only, but not their service which should be covered under Blue Shield plans, in treatment of emergency cases would result in savings to the Blue Cross Plan and a resultant conservation of the funds available for benefits of their insured; now therefore be it,

RESOLVED, that this House of Delegates instruct its Council on Medical Service to confer with the Blue Cross Commission in an endeavor to effect a revision in Blue Cross plans that will provide for payment to physicians for use of their facilities in emergency treatments.

Mr. Speaker, we recommend that this resolution be presented to the House of Delegates for its disposition.

Motion was made, seconded and carried that this resolution on Blue Cross benefits be adopted.

Mr. Speaker, I move the adoption of the report as a whole.

Motion was seconded and carried that the report of Reference Committee No. 4 be adopted.

REFERENCE COMMITTEE NO. 4

T. O. Meredith, M. D., Harrodsburg, Chairman
Wyatt H. Norvell, M.D., New Castle, Vice-Chairman
Everett H. Baker, M. D., Louisville
Keith Crume, M. D., Bardstown
Karl D. Winter, M. D., Louisville

REFERENCE COMMITTEE NO. 5

(Reports on Miscellaneous Business)
Charles B. Stacy, M. D., Chairman

Reference Committee No. 5 met September 21 and considered the reports of the following committees:

(Editor's Note: Reference Committee No. 5 considered the following 5 reports in a group, recommended their acceptance in a group, and the House approved the Reference Committee's report. Digests of each of the 5 committee reports follow)

Advisory Committee to the Editor

(The report discussed improvements in the Journal, advertisements, case reports and the Board of Consultants on Scientific Articles.)

Insurance Committee

(1. The Committee recommends to the House of Delegates that the Better Business Bureau publisned pamphlet entitled, "Facts You Should Know About Health and Accident Insurance," be purchased in the amount of 2,000 copies and copies be sent to every member of the Association in individual mailing with a letter pointing out the doctor's obligation in the matter of helping the public understand how to purchase a reliable health and accident insurance policy and a recommendation that the doctors purchase and distribute the pamphlet.

2. The question of some insurance companies not paying for procedures in the office but paying for the identical procedure at a hospital was discussed. It was felt that this was unwise discrimination against some physicians and that it unnecessarily increased the cost of insurance to the public. The committee went on record opposing this procedure and recommended to the House of Delegates that study be continued to find an answer to this problem.

3. The committee discussed the need for a standard form of claim blank. The report stated that the committee had investigated this matter with the insurance people and that the insurance industry had promised a unified claim blank by 1955. The committee recommended that if such a form had not been developed by the time of the 1955 meeting that the House of Delegates authorize the Association to set up its own standard claim form.)

Committee to Study Medical Examiner System

(The committee recommends that the Kentucky State Medical Association cause to be started and vigorously support legislation creating a State Laboratory for the investigation of unnatural deaths within this state. The committee urges that the state make available funds for the establishment of such a laboratory and salaries for the required personnel, to be headed by a physician qualified in pathologic anatomy, who must be certified by or meet the requirements for certification of the American Board of Pathology. The laboratory must have a subdivision of toxicology headed by a person specially trained in toxicology and acceptable to the Director of the Laboratory. Funds must also be available for the necessary technical assistants needed and it is urged that the laboratory be established in Louisville. The laboratory should be a separate division with the Director responsible directly to the Governor of the State. The directors appointed should be on a merit basis and completely divorced from politics. The committee further urges the Kentucky State Medical Association to vigorously support legislation for a statutory provision that the elected coroner of each county be a doctor of medicine, wherever a doctor of medicine is available for this position.)

Advisory Committee on Industrial Medicine and Surgery

(The committee urges that occupational diseases be reported to the State Department of Health where some free laboratory services are available for physicians. The committee recommends that the Guiding Principles of Occupational Medicine, as revised and approved by the Council on Industrial Health of the American Medical Association, be approved by the Kentucky State Medical Association, deleting all of paragraph 2 except the last sentence under Item 2 of **General Relations**, page 3.)

Committee on Technical Exhibits

(The report discussed the promotion of technical exhibits at the annual meeting and stated a new booth was added to make a total of 61 spaces available for rental.

These were approved as submitted.

Mr. Speaker, I move the adoption of this section of the report.

Motion was seconded and carried that the reports of the Advisory Committee to the Editor, Insurance Committee, Committee to Study the Medical Examiner System, Committee on Industrial Medicine and Surgery, and Committee on Technical Exhibits be adopted.

The following committees had no meetings and had been referred no material to be acted on by this Reference Committee:

Advisory Committee to the Woman's Auxiliary
Advisory Committee on Physical Therapy
Committee on World Medical Association
K. S. M. A. Pharmacy Committee

Mr. Speaker, I move the adoption of this section of the report.

Motion was seconded and carried that the reports of the Advisory Committee to the Woman's Auxiliary, Advisory Committee on Physical Therapy, Committee on World Medical Association and K.S.-M.A. Pharmacy Committee be adopted.

Report of the Veterans Committee

(Highlights of the report were discussions on increase in fee schedule of home-town medical care contract, endorsement of mandate of the A. M. A. regarding hospitalization of non service connected disability cases, and formation of a liaison committee with representatives from the committee, veterans organizations, Kentucky Hospital Association and Kentucky State Dental Association.)

The Report of the Kentucky State Medical Association's Veterans Committee was considered and their work is to be commended.

Mr. Speaker, I move the adoption of this section of the report.

Motion was seconded and carried that the report of the Veterans Committee be adopted.

Report of the Advisory Committee on Tuberculosis

(The committee recommended the following:

1. That in addition to a negative serology for syphilis that a recent negative chest X-ray for tuberculosis and a certificate concerning the general health of the individual be obtained before a license for marriage is issued. It is recommended that some thought be given by K. S. M. A. to working out this problem.

2. That special efforts be undertaken to acquaint general practicing physicians with the use and possible complications of the newer drugs in the therapy of tuberculosis. This could be done by refresher courses, seminars and the like.

3. That a committee be appointed by the K. S. M. A. to take final action in the case of questionable active tuberculosis in school teachers, other school employees, and food handlers as to whether they should continue working in these occupations.

4. That, to eliminate unnecessary duplication, the Advisory Committee on Tuberculosis be discontinued as such and the members appointed from the K. S. M. A. to the Coordinating Council for the Control of Tuberculosis; form a liaison committee to replace it. It is recommended that this liaison committee report to the House of Delegates each year the recommendations of the Coordinating Council for the Control of Tuberculosis and any other pertinent information that should be brought before the House of Delegates.)

The report of the Advisory Committee on Tuberculosis was considered and Reference Committee No. 5 disapproved paragraph 2 (of the report) which recommends that "in addition to a negative serology for syphilis that a recent negative chest X-ray for tuberculosis and a certificate concerning the general health of the individual be obtained before a license for marriage is issued."

The Reference Committee disapproves paragraph 4 (of the committee's report) which states "that a committee be appointed by the K.S.M.A. to take final action in the case of questionable active tuberculosis in school teachers, other school employees, and food handlers as to whether they should continue working in these occupations."

We disapprove paragraph 5 (of the report) which states "that, to eliminate unnecessary duplication, the Advisory Committee on Tuberculosis be discontinued as such and the members appointed from the K.S.M.A. to the Coordinating Council for the Control of Tuberculosis; form a liaison committee to replace it," and recommend that further study be made by the Kentucky State Medical Association and that the present Advisory Committee on Tuberculosis be continued.

Mr. Speaker, I move the adoption of this section of the report.

Motion was seconded and carried that this section of the report be adopted.

Fayette County Medical Society Resolution on Dues

(The following resolution was read before the House of Delegates:)

At the 1953 meeting of the Kentucky State Medical Association the annual assessment was increased from $25.00 to $35.00. This was done through action upon a recommendation of the Council rather than by amendment of the By-Laws as specifically laid down in the Constitution and By-Laws of the Kentucky State Medical Association which state in Chapter XIII - Amendments:

"These By-Laws may be amended by an annual session by a two-thirds vote of all the delegates present at that session after the amendment has been laid on the table for one day."

It is also stated in the By-Laws Chapter XI - Rules of Conduct:

"The deliberations of this Association shall be governed by parliamentary usage as contained in Roberts Rules of Order, unless otherwise determined by a vote of its respective bodies."

This volume states in paragraph 45 - Amendments of Rules or Order:

"And no amendment to constitutions or By-laws shall be permitted without at least equal notice (the amendment be submitted in writing at the previous regular meeting) and by a two-thirds vote."

At the October 29, 1953, meeting of the Executive Committee of the Council it was pointed out that "the House of Delegates errored editorially by not specifically changing the By-laws when an increase in the 1954 annual dues was voted." At the December 17 meeting of the Council it was moved and passed "that an editorial change be made in the By-laws changing the dues from $25.00 to $35.00." The Fayette County Medical Society maintained at the time and still maintains that these actions were and are unconstitutional. A communication from the Judicial Council of the American Medical Association states "if the action of the House of Delegates limits or adversely affects membership in the Kentucky State Medical Association or the American Medical Association, the Judicial Council be-

lieves that the By-laws should be observed as they stand adopted or, if it is desired, the By-laws should be amended at a regular or special meeting according to the provisions of the Constitution and By-laws of the Kentucky State Medical Association." This expresses the views of the Fayette County Medical Society. In order that constitutional methods may be restored as the mode of action of the House of Delegates the following amendment to the By-laws, Chapter IX - Assessments and Expenditures; Section 1; Sentence 1 is offered:

"The assessment of thirty-five dollars per capita on the membership of the component societies is hereby made the annual dues of the Association."

Fayette County Medical Society Delegates:
John Scott, M. D.
Carl Fortune, M. D.
Theodore Adams, M. D.
Lawrence Hurt, M. D.
Coleman Johnston, M. D.
Lewis Bosworth, M. D.
Richard Elliott, M. D.

Following discussion, it was moved and seconded that the Fayette County resolution be approved and that Chapter IX, Section 1 of the Kentucky State Medical Association By-laws be changed so that the amount of the assessment read $35. The motion carried.

Mr. Speaker, I move the adoption of this report as a whole.

Motion was seconded and carried that the report of Reference Committee No. 5 be adopted.

REFERENCE COMMITTEE NO. 5

Charles B. Stacy, M. D., Pineville, Chairman
Kenneth L. Barnes, M. D., Princeton
Frank Duncan, M. D., Monticello
Roy H. Moore, Jr., M. D., Louisville

Under unfinished business, J. Farra Van Meter, M. D., pointed out that the House of Delegates had acted only on the resolution presented by the Council and had not approved the final report of the Council. Doctor Van Meter moved that the House approve the final report of the Council. Motion was seconded and carried.

At this time the following were elected to fill the vacant offices for the coming year:

President-Elect...J. Gant Gaither, M. D., Hopkinsville

Vice Presidents:
Central.....Arthur T. Hurst, M. D., Louisville
Eastern..Coleman C. Johnston, M. D., Lexington
Western.....Jesse Funk, M. D., Bowling Green

A.M.A. Delegate..Clark Bailey, M.D., Harlan

Alternate A.M.A. Delegate....W. Vinson Pierce, M.D., Covington

While the ballots were being counted, Daniel Bower, M. D., Barbourville, discussed problems concerning the relationship of the medical profession with the veterans' organizations. He said that while the individual doctor is still respected by members of veterans' groups, as a part of the A.M.A. the doctors are considered antagonistically. He urged the physicians who are veterans to take an active part in the veteran group activities in order to have a better understanding of the veteran's viewpoint, thus creating better public relations.

At this time the delegates from the counties in the districts which were to elect councilors and who had held individual meetings after the first session of the House presented their nominations and the following councilors were elected:

Fifth District..Richard R. Slucher, M. D,. Buechel
Sixth District.....L. O. Toomey, M. D., Bowling Green
Eighth District....Edward Mersch, M. D., Covington
Eleventh District..Hugh Mahaffey, M. D., Richmond
Fifteenth District .Charles B. Stacy, M.D., Pineville

The Speaker said he would entertain a motion that the House of Delegates authorize Mr. Joe Sanford to draw appropriate letters of appreciation to all organizations, agencies and individuals which have contributed in any way to the success of this meeting.

It was moved and seconded that this be done and the motion carried.

The Nominating Committee to serve at the 1955 Annual Meeting was elected as follows:

Howell Davis, M. D., Owensboro
Carlos Fish, M. D., Louisville
Coleman C. Johnston, M. D., Lexington
Robert W. Robertson, M. D., Paducah
H. B. Stone, M. D.. Hopkinsville

There being no further business a motion was made, seconded, and carried that the meeting adjourn at 10:00 P. M.

Publication see: Jour. Kentucky St te Med. Assoc., Vol. 53, No. 1, Jan. 1955, p. 64.

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Jesse T. Funk, 528 E. Main St., Bowling Green — Vice-President
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Charles A. Vance, 271 W. Short Street, Lexington — Speaker—House of Delegates
E. W. Jackson, 333 Broadway, Paducah — Vice-Speaker—House of Delegates
Branham B. Baughman, 401 W. Main St., Frankfort — Chairman of the Council
Richard R. Slucher, Buechel — Vice-Chairman of the Council

DELEGATES TO THE A. M. A.

	Term Expires
Bruce Underwood, 620 S. Third Street, Louisville	1955
Coleman Johnston, 211 W. Second Street, Lexington (Alternate)	1955
W. Clark Bailey, Harlan	1956
W. Vinson Pierce, 33 E. Seventh St., Covington (Alternate)	1956

COUNCILORS

		Term Expires
First District	J. Vernon Pace, 709-10 Citizens Bank Building, Paducah	1956
Second District	Walter L. O'Nan, 700 N. Elm St., Henderson	1955
Third District	Delmas M. Clardy, Hopkinsville	1956
Fourth District	W. Keith Crume, Bardstown	1956
Fifth District	Richard R. Slucher, Buechel	1957
Sixth District	L. O. Toomey, 544 E. Main St., Bowling Green	1957
Seventh District	Branham B. Baughman, 401 W. Main St., Frankfort	1955
Eighth District	Edward B. Mersch, 92 Arcadia, Covington	1957
Ninth District	J. M. Stevenson, Brooksville	1955
Tenth District	J. Farra Van Meter, 183 N. Upper Street, Lexington	1955
Eleventh District	Hugh Mahaffey, Richmond	1957
Twelfth District	Garnett J. Sweeney, Liberty	1956
Thirteenth District	Charles B. Johnson, Russell	1955
Fourteenth District	John Archer, Prestonsburg	1956
Fifteenth District	Charles B. Stacy, Pineville	1957

EDITORIALS

THE RURAL HEALTH CONFERENCE NEEDS YOUR HELP

The solution of many, if not most, of Kentucky's health problems can best be achieved at the local level. It is equally true that nothing can surpass an alert, informed and active public, eager to act collectively and as individuals in meeting these problems.

The importance of voluntary community and individual action is especially great in Kentucky's rural communities. For this reason the Kentucky Rural Health Council movement is especially worthy of active support by every physician.

Whether it be sanitation on the farm, good nutrition, farm and home safety, immunization of children, maintenance of good dental practices or any of a host of other health problems, there is an important place in every Kentucky community for voluntary cooperative effort by and through an active rural health council.

The local rural health council provides a means for all segments of the community to counsel together on health problems. It provides an instrumentality through which laymen can work together to solve those health problems which are their rightful province and to which they alone can in the last analysis bring solutions.

Because the Rural Health Council movement is a voluntary effort from top to bottom, no one will come into a community and say - "You need a rural health council. Here is how you should set it up. Here is what it should do for you."

The whole local action must begin with an individual or a group at the community level. This, of course, calls for an initial interest.

The creation of such an interest - the spark, if you will - is the objective of the annual Kentucky Rural Health Councils sponsored by the Kentucky Rural Health Council and the Rural Health Committee of the Kentucky State Medical Association. The conference has meaning to the extent that it awakens such an interest in folks back home. This means that they must attend the conference.

KSMA members can do much to strengthen the conference and the rural health council movement by urging their patients and other friends - the lay leaders in their own community - to attend the 1955 conference at the Kentucky Hotel in Louisville, Thursday, January 20.

This conference, which represents one of the medical profession's major public service contributions, will succeed to the extent that we physicians encourage the laymen to come. Physician attendance is also important. Plan now to attend this all day meeting yourself if you can. If you cannot, be sure and see that a car-load of lay leaders come from your community.

UNITED MINE WORKERS OF AMERICA HOSPITAL PLANS

The Memorial Hospital Association, which is sponsored by the United Mine Workers of America Welfare and Retirement Fund, has under construction 10 hospitals with an anticipated bed capacity of approximately 1,000. Seven of these are in Kentucky:—close to Williamson, W. Va., at Pikeville, at McDowell, at Whitesburg, at Hazard, at Harlan, and at Middlesboro. The other three are at Beckley and Mann, W. Va. and at Wise, Va. All these hospitals are to have out-patient clinics. Three - those at Beckley, near Williamson and at Harlan - are to have very complete equipment and serve as diagnostic and treatment centers. Training schools for graduate and practical nurses are contemplated. It is anticipated that the hospitals will be fully accredited by the Joint Commission on Accreditation of Hospitals and that an intern and resident training program will be included.

Such a program will have a powerful impact on medical practice in Eastern Kentucky. It can mean much in better medical care to the people of that section. Its measure of success is certain to be watched with great interest by other labor unions which sponsor health and welfare programs. The problems associated with this venture into hospital construction and

operation was one of the main subjects considered at a conference held in Huntington, W. Va., October 3 and 24, 1954 under the auspices of the Committee on Medical Care of Industrial Workers of the A.M.A. Representatives of the UMWA Welfare Fund outlined the general plans. There was agreement on many points, on others representatives of State Medical Associations, particularly those representing the KSMA., took exception.

Organization of the medical staffs of the Memorial Hospitals was one of the main topics. All were in hearty agreement with the announced intention of making the staff open to qualified and ethical practitioners in the area. There was much discussion of the limitation of staff privileges on the basis of training and experience. The program contemplates specialists already certified or eligible for certification by the various specialty boards. *No clear statement was made concerning the scope of staff privileges to be allowed the general practitioners.* The KSMA representatives feel that the general practitioner is the keystone of medical practice, especially so in rural areas, and we have urged, and will continue to urge, as wide hospital privileges as possible for him. It was specifically stated that the Memorial Hospitals would be available to non-miners, if there were beds not occupied by UMWA beneficiaries.

There was much discussion of the method of payment to physicians for care of UMWA beneficiaries. The KSMA is committed by action of its House of Delegates to the principle that fee-for-service payment and free choice of physician is in the best interest of good medical care. The UMWA Welfare Fund prefers in many instances a lump sum payment for the care of all UMWA beneficiaries. They point out that this is a well recognized form of payment for medical services and that the Council on Medical Ethics of the A.M.A. has stated it is not unethical, if there is no exploitation of the physician. This issue has already arisen in Eastern Kentucky and is almost certain to arise again. Nothing said in the Huntington conference indicated that coercion would be used to get physicians to accept retainer fees, but this form of payment will almost certainly be offered to some. *County medical societies are urged to carefully consider all aspects of the problem before adopting a policy.*

Lay-sponsored medical clinics exist in some states and have been utilized by the UMWA Welfare Fund for the care of beneficiaries. The Pennsylvania Medical Society recognizes these organizations and outlined a program they have set up for controlling them. The KSMA representatives strongly opposed the principle of lay control of medical practice. Our state laws provide that only those licensed by the State Board of Health can practice medicine. We believe that any organization which controls medical practice is, in fact, practicing medicine and that accordingly control must rest in licensed doctors of medicine. As far as is known, no lay-sponsored groups exisit in Kentucky, *but County Medical Societies are urged to be alert for such developments.*

The Huntington conference showed that many of the problems which have arisen in Kentucky between physicians and the UMWA Welfare Fund are also present in other states. The Fund and the physicians both wish to improve medical care in the coal mining area. The Tennessee State Medical Society has made much progress working in cooperation with the UMWA Welfare Fund in improving medical care in its most backward areas. The KSMA Advisory Committee feels that cooperation on the local level and on the state level is possible without sacrifice of principle and that it is in the best interest of good medical care. With this end in view a member of the State Advisory Committee has been designated as the contact man for the County Medical Societies in his area. These are: Clark Bailey, M. D., Harlan, for Harlan, Whitley, Bell and Knox Counties; C. Dana Snyder, M. D., Hazard, for Leslie, Clay, Perry and Knott Counties; George Archer, M. D., Prestonsburg, for Martin, Floyd and Johnson Counties; William C. Hambley, M. D., Pikeville, for Pike and Letcher Counties; George Brockman, M. D., Greenville, for the Western Coal Field; Thomas V. Gudex, M. D., for Louisville; Walter Coe, M. D., University of Louisville, for Medical School problems; and Carl H. Fortune, M. D., Chairman, for Lexington and for problems of a general nature. The County Medical Society as an autonomous unit can set its own policies. The State Advisory Committee can coordinate and advise. It is hoped that through these local representatives, the problems of the individual practitioner and of the UMWA Welfare Fund can be brought to the Committee and that a sound basis for more complete cooperation can be evolved.

Carl H. Fortune, M.D., Lexington, Chairman, KSMA Advisory Committee to UMWA Welfare and Retirement Fund.

President's Page

The County Society is the basic unit of our State Association. It is an autonomous entity. This autonomy carries many obligations, and some of them are worthy of note at this time.

1. The County Society should accept the responsibility of leadership in community health efforts. Such a leadership would go far toward solving most local health problems.
2. It is the obligation of the County Society to provide educational advancement both for its membership and the public.
3. Our County Societies should be willing and able to control locally any violation of ethical practice.
4. With the expansion of health insurance plans and health matters entering so frequently into labor-management contracts, the County Society must be in position to advise as to the soundness of a program and the feasibility of its implementation.
5, The County Society should be actively concerned in solving the problem of caring for the indigent.
6. Therefore, if we are to be leaders instead of followers, we should make our decisions on fundamental principles rather than on a fear of some consequence.

The basic mechanism for the proper functioning of our County Societies is present. Will we accept these responsibilities and use this mechanism to the fullest?

L. C. Sparks

PRESIDENT

ORGANIZATION SECTION

Early Reports Forecast Success Of Detection Drive

The results of the 1954 statewide Diabetes Detection Drive sponsored by the KSMA and its component county societies in cooperation with the American Diabetes Association during National Diabetes Week, November 14-20, are still coming in from county chairmen, according to Carlisle Morse, M.D., Louisville, chairman of the KSMA Diabetes Committee.

"Since the purpose of the drive is to actually detect previously undiscovered diabetics, it is important that careful follow-through on the urine positives be made before reports are made by the counties," Dr. Morse said. "Because this presents a real problem in some of the counties, it is to be expected that considerable time will elapse before some reports from the counties come in.

"Every indication received to date, however, indicates that the 1954 drive was again quite successful. The KSMA Diabetes Committee wants to express its appreciation for the fine job done by physicians in this important public service program."

Ky. Rural Health Conference Set For Jan. 20, Louisville

Plans for the 1955 Kentucky Rural Health Conference have been announced by Wyatt Norvell, M.D., New Castle, chairman of the Kentucky Rural Health Council and the KSMA Rural Health Committee.

The conference, which is sponsored by the KSMA Rural Health Committee and the approximately 20 state-wide groups which make up the Kentucky Rural Health Council, will be held one day only, Thursday, January 20. This is a change from previous custom, in which the conference has begun in the afternoon of one day and ended at noon of the next.

"The decision of the program committee to change to a one-day meeting was made because of the view held by some that the expense and inconvenience of an overnight attendance in some cases kept the farmer and other laymen from attending in the numbers desired," Dr. Norvell said.

"Since the primary purpose of the conference is to arouse the enthusiasm of the people themselves for voluntary cooperative action for better health through the formation and work of local rural health councils, it is important that we make every effort to see that the farmer, the minister, the teacher, the homemaker and others who must lead the movement at the local level attend these conferences. We hope that our experiment with the one-day meeting may be helpful in this regard."

A full program is being developed for the conference. Registration will be at 9:00 a.m., Thursday, January 20, and the meeting will adjourn at 4:00 p.m. A nationally prominent speaker is expected to address the luncheon session. Among the subjects to be covered in the conference are nutrition, immunization, sanitation on the farm and in the schools. Additional details will be published in the next issue of the KSMA Journal.

April 7 Officers Session Presents Outstanding Speakers

Several nationally recognized speakers have been engaged to speak at the Fifth Annual County Society Officers Conference, which will be held at the Phoenix Hotel, Lexington, on Thursday, April 7.

Arrangements for the meeting, according to KSMA President, Clyde C. Sparks, M.D., Ashland, are well-advanced.

Dr. Sparks urged all county medical society officers, both new and old, to make their plans to attend the April 7th session.

KSMA Sends 11 to Huntington for Medical Care Conference

Eleven representatives of the KSMA, headed by Carl Fortune, M.D., Lexington, Chairman of the KSMA Advisory Committee to UMWA Welfare and Retirement Fund, attended the Third Conference on Medical Care in the Bituminous Coal Mine Area, October 23 and 24 in Huntington, West Virginia.

The conference, which was sponsored by the AMA's Committee on Medical Care for Industrial Workers, of which Clark Bailey, M.D., Harlan, is a member, has as its goal "the finding of ways to improve medical and hospital care in the bituminous coal mining areas."

Prominent among the Kentucky delegation were Clyde C. Sparks, M.D., Ashland, KSMA President; Gant Gaither, M.D., Hopkinsville, President-elect, and Dr. Bailey.

Dr. Fortune reported for the Kentucky committee and Asa Barnes, M.D., Louisville, UMWA Area Administrator, reported for his organization. Elmer Hess, M.D., Erie, Pennsylvania, President-elect, AMA, spoke at a luncheon during the conference.

One of the most informative presentations was made by Aims C. McGuinness, M.D., Washington, D. C., the recently appointed Clinical Director of the Memorial Hospital Association, which is the agency of the Welfare Fund dealing with construction and operation of the Fund's hospitals. Dr. McGuinness, who is in charge of the staffing of hospitals and setting up educational programs, gave detailed data on the hospital program.

Other members of the KSMA in attendance were: John Archer, M.D., Prestonsburg; George F. Brockman, M.D., Greenville; W. C. Hambley, M.D., Pikeville; Adam G. Osborne, M.D., Pikeville; Charles Rutledge, M.D., Pikeville; and Charles B. Stacy, M.D., Pineville.

"Mr. Southern Medical" Retires From SMA Official Family

C. P. Loranz, known throughout the south as "Mr. Southern Medical" retired as Executive Secretary and Treasurer of SMA at the close of the Association's forty-eighth annual meeting in St. Louis in November. M. Y. Dabney, M.D., who has been Editor of the Southern Medical Journal for thirty years, and Mrs. Dabney, who has served as Assistant Editor, retired at the same meeting.

Mr. Loranz was succeeded by V. O. Foster, former Executive Secretary of the Tennessee State Medical Association, who took over his new responsibilities on December 1. Rudolph H. Kampmeir, M.D., Chief of the Medical Clinic of Vanderbilt University Hospital and Professor of Medicine and Director of Postgraduate Instruction of Vanderbilt University School of Medicine, took over the duties of Dr. Dabney.

Mr. Loranz will continue at the request of SMA Council in an active advisory and professional relations capacity for the next three years. During his forty-two years with the Association, Mr. Lorenz has seen its "membership grow from a few hundred to a few thousand," and has seen "the Association progress from a comparatively obscure organization with a few loyal followers, to an organization nationally and internationally known and respected with a host of loyal followers."

Mr. Foster is a graduate of the University of Tennessee and taught science in the public high schools for several years. Prior to his coming into Tennessee State Medical Association, he held a responsible post in the field of municipal administration. Since August Mr. Foster has been working in the SMA office to acquaint himself with his new duties. Well-versed in administrative detail, the eight years spent with the TSMA have given him a good background for his present responsibilities.

Dr. Kampmeir received both his B.A. and his M.D. from the University of Iowa. His editorial experience includes the Assistant Editorship of the "American Practitioner and Digest of Treatment," a post he has held since 1946, and since 1950, the Editorhip of the Journal of the Tennessee State Medical Association. He is the author of two textbooks on medicine.

Policy on Hospital Accreditation Announced by Commission

Hospital officials are becoming increasingly concerned with the matter of how long a hospital may stay Provisionally Accredited. For this reason, the Joint Commission on Accreditation of Hospitals has adopted the following policy:

"If a hospital with Provisional Accreditation continues to be Provisionally Accredited on the second survey, the hospital will be told that it will be surveyed again the following year and if it does not then meet the standards for Full Accreditation, it will be dropped to No Accreditation. This will be conveyed to the hospital in writing."

Kenneth B. Babcock, M.D., has succeeded Edwin L. Crosby, M.D., as director of the Joint Commission, according to an announcement in their October Bulletin. Member organizations include: American College of Physicians, American College of Surgeons, American Hospital Association, American Medical Association, and the Canadian Medical Association.

Jefferson Co. Bulletin Committee Congratulated by Dr. Sparks

The improved and enlarged Bulletin of the Jefferson County Medical Association made its first appearance in its new dress beginning with the November issue.

Clyde C. Sparks, M.D., Ashland, KSMA president, congratulated the Bulletin Committee, which is composed of Marvin Lucas, M.D., Editor, Blaine Lewis, M.D., and John Smith, M.D., Co-Editors, all of Louisville, on the development of this new monthly publication.

The new magazine, in addition to the President's Page and a discussion of the next meeting to be held by the Association, carried pictures and a thumb-nail biographical sketch of new members, Schedule of Specialty and Hospital Staff Meetings, "The Dean's Page," and news from the Woman's Auxiliary.

Dr. Norvell to Address National Rural Health Conference

Wyatt Norvell, M.D., New Castle, Chairman of the KSMA Rural Health Committee, will speak at the Tenth National Rural Health Conference, which will be held at the Schroeder Hotel in Milwaukee, February 24-26.

"Using Our Present Health and Medical Care Resources" will be discussed by Dr. Norvell from the physician's point of view. He will also serve as a consultant on a panel which will be presented at the conference.



Dr. Norvell

Dr. Norvell is chairman of the Kentucky Rural Health Council and the immediate vice-president of the Kentucky State Medical Association. He actively participates in health and civic affairs in his home community.

The theme of this conference, which is sponsored each year by the Council of Health of AMA, will be "Looking Both Ways." Accident prevention and family responsibility in matters of health will be highlighted.

Approximately 700 farm extension, medical, and health education leaders are expected to attend this annual feature. George F. Bond, M.D., Bat Cave, North Carolina, who is presently serving in the armed forces, is Kentucky's representative on the AMA Council.

KSMA Members Urged to Mail In AMA Directory Data

All KSMA members are urged to send in the directory information card, properly filled out, which has recently been mailed to every physician in the United States, its dependencies, and Canada.

According to a request from the Directory Department of AMA, every physician should mail a card promptly to insure accurate listing of his name and address even though he may have sent in similar information recently.

This is the first new edition of the American Medical Directory since 1950. The Directory is one of the most important contributions of the AMA to the work of the medical profession. In it may be found dependable data concerning physicians, hospitals, medical organizations, medical schools, specialization in the fields of medical practice, memberships in special medical societies, and statistics on the distribution of physicians and hospitals in the United States.

6th District Held Dinner Meeting Last Month in Bowling Green

The Warren-Edmonson County Medical Society was host to the Sixth Councilor District at its quarterly dinner meeting held Thursday, November 9, at 6:30 p.m., at the Archway Inn in Bowling Green, according to L. O. Toomey, M.D., Councilor, Sixth District.

Talks by two members of the Sixth District featured the scientific program. "Spine Injuries" was discussed by William O. Carson, M.D., of Bowling Green, and "Abdominal Injuries" by John P. Glenn, M.D., of Russellville.

Walter Bryne, M.D., District President, presided at the meeting. Arrangements for the meeting were made by District Secretary, Richard F. Grise, M.D., Bowling Green.

Cardio-Vascular Symposium Set Jan. 21, Louisville

The Louisville Heart Association is announcing its First Annual Symposium on Cardio-Vascular Diseases to be held in Louisville in the Fred Rankin Amphitheatre on January 21. The Symposium will be co-sponsored by the University of Louisville School of Medicine.

The program has been arranged to present significant advances in Cardio-Vascular diseases as relates to diagnosis and treatment, but time will be devoted also to both clinical and experimental research in this field. Guest speakers will be Emmet B. Bay, M.D., of the Department of Medicine, University of Chicago and Floyd Denny, M.D., of the Department of Pediatrics at the Vanderbilt University School of Medicine, Nashville.

In addition to the guest speakers six clinicians from the Louisville area will talk on other topics of interest. They are John S. Harter, M.D., Walter Coe, M.D., George W. Pedigo, M.D., John A. Hemmer, M.D., Leonard Leight, M.D., and Ralph Denham, M.D.

All interested Kentucky physicians, interns, residents, and medical students have been invited to attend these sessions, for which no registration fee will be required.

Kentucky Anesthesiologists to Meet In Louisville January 16

The Kentucky Society of Anesthesiologists will meet in Louisville on Sunday, January 16, 1955, Robert P. Bergner, M.D., President-elect of the Society, has announced.

Approximately 35 members are expected to be present at a combination dinner, business

meeting and scientific program at the Brown Hotel. The Society meets three times a year, according to Dr. Bergner.

There will be two speakers on the scientific program. J. J. Jacoby, M.D., Professor of Anesthesiology at Ohio State University, will speak on "Effects of Vagal Stimulation During Cyclopropane Anesthesia," and George W. Schafer, M.D., Instructor in Anesthesiology at the University of Louisville Medical School, will talk to the group on "Clinical Studies with Nalline."

Eye, Ear, Nose and Throat Group Of KSMA Elects Officers

Charles M. Francis, M.D., Bowling Green, was elected 1955 president of the Eye, Ear, Nose and Throat Section of KSMA at a meeting of the group in Louisville on November 1, 1954. Dr. Francis succeeds R. A. Gettelfinger, M.D., of Louisville.

Approximately 45 members of the Section attended the meeting. Speakers were Ben H. Senturia, M.D., Professor of Otolaryngology at Washington University, St. Louis, and Charles E. Iliff, M.D., Assistant Professor of Ophthalmology at Wilmer Institute of Johns Hopkins Hospital, Baltimore.

Other officers elected were vice-president, Wyant Dean, M.D., and secretary, Buerk Zimmerman, M.D., both of Louisville. Arthur Keeney, M.D., Louisville, was elected treasurer for a two-year term in 1953.

Additional Members Appointed To Committee on School Health

Accepting the recommendations of the Committee on School Health, the 1954 Session of the House of Delegates authorized the president to name a member from each Councilor District to serve on this committee.

The October Journal of KSMA carried the list of original appointees to the committee. New members, as authorized by the House of Delegates and appointed by KSMA President, Clyde C. Sparks, Ashland, are listed below:

First District, Conrad Jones, M.D., Murray; Third District, Hylan H. Woodson, M. D., Greenville; Fourth District, John D. Handley, M. D., Hodgenville; Ninth District, Benjamin F. Allen, M. D., Flemingsburg; Tenth District, James S. Williams, M.D., Nicholasville; Eleventh District, Vernon Kash, M. D., Winchester; Twelfth District, McLeod Patterson, M. D., Somerset; Fifteenth District, Boyce E. Jones, M.D., London.

Kentucky Nurses Week Celebration Honors "Nurse Of The Year"

High point of Kentucky Nurses Week, celebrated in connection with National Nurses Week, October 10-16, was the Tribute Dinner honoring the Kentucky Nurse of the Year, Miss Martha Schafer, which was held at the Kentucky Hotel, October 16.

In a wire sent by Clyde C. Sparks, M. D., president, the KSMA extended its best wishes to the Kentucky League for Nursing and the Kentucky Association of Registered Nurses in their celebration of Nurses Week.

Miss Schafer, who is a clinical instructor in pediatric nursing at St. Joseph Infirmary and a member of the St. Joseph School of Nursing faculty, is the first nurse to be thus honored, this being the first year the Kentucky League of Nursing has offered such recognition.

Eleventh District Hears Dr. Sparks Nov. 4 at Richmond

Clyde C. Sparks, M.D., KSMA President, Ashland, was the featured speaker at the annual dinner meeting of the 11th Councilor District, November 4, which was held at the Benault Inn in Richmond, according to an announcement of Hugh Mahaffey, M.D., Richmond, Councilor.

Approximately 50 physicians who practice in the district, and their wives, heard Dr. Sparks discuss "Our Medical Freedoms."

Hubert C. Jones, M.D., President of Madison County Medical Society, welcomed the visitors. William K. Keller, M.D., Louisville, head of the Psychiatric Service at the Louisville General Hospital, presented the scientific program. His subject was "Psychiatry for the General Practitioner."

Dr. Sparks Announces Formation of "Senior Day" Committee

The "Senior Day" proposal of the Education Campaign Committee and the Council was approved by the House of Delegates at the 1954 annual session, and the president was authorized to undertake the program.

W. Vinson Pierce, M.D., Covington, Chairman of the Education Campaign Committee, was named Chairman of the "Senior Day" Committee by KSMA President Clyde C. Sparks, M.D., Karl D. Winter, M.D., Louisville, Chairman of the Medical School Advisory Committee; Glenn W. Bryant, M.D., Louisville,

Chairman of the Public Relations Committee, and W. O. Johnson, M.D., Advisor to University of Louisville Medical School Student AMA Chapter, were also appointed to serve on the committee.

The proposal calls for a day-long program for the senior class of the University of Louisville School of Medicine, which would deal with a variety of topics important to physicians upon entering the field of medicine, Dr. Sparks said.

Medical School Makes Appointments To Its Teaching Staff

Approval of the appointment of seven physicians to the staff of the University of Louisville School of Medicine has been announced by university trustees.

Alfred M. Berg, M.D., a graduate of the University of Louisville School of Medicine in 1945, William T. Rumage, Jr., M.D., a graduate of New York University College of Medicine in 1946, and Herman Mahaffey, M.D., a graduate of the University of Louisville School of Medicine in 1946, have been named instructors in surgery.

David H. Neustadt, M.D., a graduate of the University of Louisville School of Medicine in 1950, Robert S. Tillett, M.D., a graduate of Western Reserve University School of Medicine in 1946, and Albert G. Goldin, M.D., a graduate of the University of Louisville School of Medicine in 1946, have been appointed instructors in medicine.

Allan F. Zoeller, M.D., a graduate of the University of Louisville School of Medicine in 1948, will serve as instructor in orthopedic surgery.

Shelby County Physician Honored For Fifty Years' Service

Tribute to E. W. Frymire, M.D., Graefenburg, for fifty years' service in Shelby, Franklin and Anderson Counties was paid by 700 of his patients and friends on Sunday, October 17, in the Bridgeport School auditorium.

Among those present were 170 persons who were delivered as babies by Dr. Frymire during half a century of medical practice. Special recognition was given the group, ranging in age from 48 to three years.

A Shelbyville attorney, H. B. Kinsolving, praised the 73-year-old physician as "a man whose first duty was service...who braved all kinds of weather to minister to the sick."

His friends, in gratitude, presented a number of gifts to Dr. Frymire and his wife.

3 New Committee Appointments Announced by Dr. Sparks

President Clyde C. Sparks, M.D., Ashland, has announced three recent appointments to KSMA committees.

W. O. Johnson, M.D., of Louisville, has been appointed to serve as the KSMA member on the Advisory Committee of the Student AMA. Dr. Johnson succeeds John S. Llewellyn, M.D., who resigned.

Lenora P. Chipman, M.D., Williamstown, has been appointed to the Advisory Committee on Pediatrics, and Walter S. Coe, M.D., Louisville, to the Advisory Committee on United Mine Workers Welfare and Retirement Fund.

Jefferson County Medical Society Votes to Approve Project

The Jefferson County Medical Society at its regular monthly meeting October 18 voted to override the objections of the society's hospital committee to the erection of a proposed 10-story office building for physicians to be built on the grounds of St. Joseph Infirmary in Louisville.

The committee's objections to "a professional office building in close proximity to a private hospital" had been based on the possible danger of a "closed staff" hospital system.

However, the society as a whole approved the project and its chairman, Henry B. Asman, M.D., said that plans would proceed. Dr. Asman said that approximately 80 physicians have already expressed interest in such an office building and that permission for the purchase of adequate space on the infirmary grounds has been received.

The Medical Society also voted to study the advisability of purchasing the property at Brook and College Streets as a possible home for the society.

Students are "Family Doctors" in New Care-Training Program

Students are "family doctors" in a new care-training program at the University of Louisville School of Medicine, which is sponsored by the Kellogg Foundation, Battle Creek, Michigan.

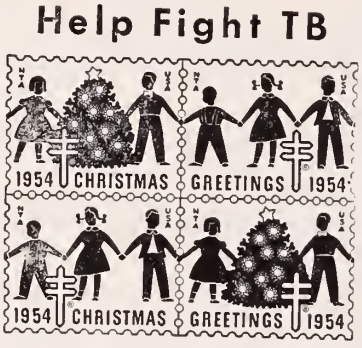
C. Howe Eller, M.D., Louisville, chairman of the Medical School's department of community health, requested the grant and is advisor for the program. For 19 families of the community the plan provides a "family doctor" in the form of a medical student. For the students it provides opportunity to "see what medicine

does to the patient."

Eight medical students began the program in Louisville last year and are continuing with the same family this year. Eleven more Medical School juniors were assigned to families last month. The students work under the supervision of a teaching committee and in consultation with physicians at General Hospital and a medical-social consultant.

Sponsors Christmas Seal Sale

The 48th annual Christmas Seal Sale began on November 22 and will continue through December, it was announced by E. R. Gernert, M.D., Louisville, president of the Kentucky Tuberculosis Association.



Buy Christmas Seals

Last year $298,000 was raised for the work of the Association in the state of Kentucky. Ninety-four cents of every dollar collected in Kentucky stays in the state and is used for health education, case-finding, rehabilitation and patient services. Other activities of the Kentucky Tuberculosis Association during the past year included the organization of the Kentucky Trudeau Society. This group of physisians will act in a medical advisory capacity to the Kentucky Tuberculosis Association.

Post Graduate Program Given

The Kentucky Academy of General Practice and the University of Louisville School of Medicine presented a Post Graduate Program at the Lafayette Hotel in Lexington on November 18. The program was followed by a dinner, to which the wives of the members were invited.

Appearing on the program were Everette Sannaman, M. D., Joseph Little, M.D., and Walter S. Coe, M.D., all of Louisville. The after dinner speaker was Malcolm Phelps, M. D., National Director of the American Academy of General Practice.

KSMA Members Address SMA

The forty-eighth annual meeting of the Southern Medical Association, which was held in St. Louis, Mo., November 8-11, numbered among its speakers several KSMA physicians.

Speakers and their subjects included: Samuel A. Overstreet, M.D., Louisville, "Diagnosis of Small Bowel Lesions;" Lloyd D. Mayer, M.D., Lexington, "An Experimental and Clinical Evaluation of the Corticosterioids in Allergy;" John Petry, M.D., and B. Pearson, M.D., Louisville, "Obstetrical Complications of the Grand Multipara;" Joseph E. Maurer, M.D., and Robert Lich, Jr., M.D., Louisville, "Retropubic Prostatectomy: An Analysis of 750 Cases," and Charles Dwight Townes, M. D., Louisville, "Cataract Surgery in Diabetic Patients."

Surgeons Hear Dr. Churchill

"Wound Healing" was the subject of this year's annual Yandell Lecture, sponsored by the Louisville Surgical Society. The speaker was Edward D. Churchill, M.D., Professor of Surgery, Harvard University Medical School at the Massachusetts General Hospital.

The lecture, held November 11 in the Rankin Amphitheatre, Louisville General Hospital, was attended by many KSMA members from out in the state. Following the lecture, a dinner honoring Doctor Churchill was held at the Pendennis Club.

Color TV Will Feature '55 Meeting

Color television will be a feature of the scientific program of the 1955 annual meeting, which will be held in Louisville at the Columbia Auditorium September 27, 28 and 29, Clyde Sparks, M.D., President of KSMA and Chairman of the Committee on Scientific Assembly, has announced.

Rudolf J. Noer, M.D., head of the Department of Surgery at Louisville General Hospital, will be the chairman of a special sub-committee responsible for setting up the TV programs, Dr. Sparks said. Garnett J. Sweeney, M.D., Liberty, is co-chairman of the sub-committee. Other committee members are J. C. Bell, M.D., Louisville, Rankin C. Blount, M.D., Lexington, James C. Drye, M.D., Louisville, and Lawrence T. Minish, Jr., M.D., Louisville. Special receivers will be installed at Columbia Auditorium for the programs, which will be televised, over Smith, Kline and French Color TV equipment, from General Hospital.

Dr. Hermann Heads Ky. Group

The Campbell-Kenton County Medical Society was the first county society to report the result of its 1955 election of officers, which was held in Covington at the Society's November 4 session.

George Hermann, M.D., Ft. Thomas, will preside in the coming year as president, according to the report sent in by Morris M. Garrett, M.D., Covington, the new secretary-treasurer. Other officers elected are, president-elect, John Cassidy, M.D., Covington, and vice-president-elect, Carl W. Kumpe, M.D., Covington.

Farm Safety Group Organizes

The Kentucky State Medical Association is one of the charter members of the Kentucky Farm Safety Committee recently organized under the sponsorship of the Kentucky Farm Bureau Federation.

At the request of the new state-wide group, Clyde C. Sparks, M.D., KSMA president, Ashland, has appointed Wyatt Norvell, M.D., New Castle, as the permanent representative to the new group.

Dr. J. Farra Van Meter Re-Elected

J. Farra Van Meter, M.D., Lexington, 1953-54 Chairman of the KSMA Council, was re-elected to serve a third term as president of the Kentucky Division of the American Cancer Society at the annual achievement dinner at the Brown Hotel in Louisville held November 4.

The division reported that 9,085 patients were examined in the past year at cancer clinics in Kentucky. More than $96,000 was spent for hospitalization of needy cancer patients, and 170,543 surgical dressings were made by division volunteers.

Virginia Society to Admit Negroes

By a vote of 166 to 101, the Medical Society of Virginia agreed to admit Negro physicians to membership, provided they are admitted to component local and county medical societies. The motion to ratify the resolution concerning their admittance was made by Walter Martin, M.D., Norfolk, who also is president of the American Medical Association. A spokesman for the society stated that three of the 46 component societies have already agreed to admit Negro physicians.



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Journal of the Kentucky State Medical Association, December 1954

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Dr. Cecil Speaks in Louisville

Russell L. Cecil, M.D., of New York, Medical Director of the National Arthritis and Rheumatism Foundation, addressed 125 physicians and medical students at General Hospital in Louisville, October 28, at a seminar sponsored by the Foundation, the Medical School of the University of Louisville, and the Kentucky Academy of General Practice. Dr. Cecil is a native of Nicholasville, Kentucky.

1955 Award Committee Appointed

Appointment of the 1955 KSMA Committee to Select the Recipients of the Distinguished Service Award and the Outstanding General Practitioner Award has been announced by Charles A. Vance, M.D., of Lexington, Speaker of the House of Delegates. Members serving on the committee are R. C. Strode, M.D., Lexington, Chairman; H. B. Stone, M.D., Hopkinsville; L. T. Minish, M.D., Louisville; P. A. Bryan, M.D., Ashland, and J. H. Kurre, M.D., Owensboro.

This committee, whose function it is to select the 1955 KSMA award winners, will make its report at the first meeting of the House of Delegates next September.

KSMA Receives 13 New Members

Thirteen physicians recently were added to the membership roster of the Kentucky State Medical Association. They are:

Herbert Bessinger, M.D., Virgie;
Robert A. Clary, M.D., Guthrie;
Joseph F. Daugherty, M.D., Florence;
George E. Estill, M.D., Maysville;
Thomas J. Ferriell, Jr., M.D., Vine Grove;
George Harris, M.D., Warsaw;
Robert G. Heimbrock, M.D., Erlanger;
W. R. Mann, M.D., Campbellsville;
Leonard M. Schultz, M.D., Fort Knox;
Harold L. Speevack, M.D., Munfordville;
John R. Stevie, M.D., Covington;
Chester L. Thornberry, M.D., Cynthiana;
Lee H. Vensel, Jr., M.D., Franklin.

American Medical Education Foundation state chairmen will hold a one-day "kick off" session on Sunday, January 23, at the Sheraton Hotel, Chicago. This meeting will officially launch a concerted effort on the part of the medical profession to raise voluntary funds for medical schools throughout the country. State chairmen present will exchange ideas on local promotion.

Amebiasis[1] a "Poorly Reported" Disease

Until serious complications arise, amebiasis may pass unrecognized and patients receive only symptomatic treatment.

Although amebiasis is a disease with serious morbidity and mortality, statistics on its incidence[1] are incomplete because its manifestations are not commonly recognized and consequently not reported.

"*Vague symptoms[2] referable to the gastrointestinal tract, such as indigestion or indefinite abdominal pains, with or without abnormally formed stools, may result from intestinal amebiasis. Not infrequently in cases in which such symptoms are ascribed to psychoneurosis after extensive x-ray studies have been carried out, complete relief is obtained with antiamebic therapy.*"

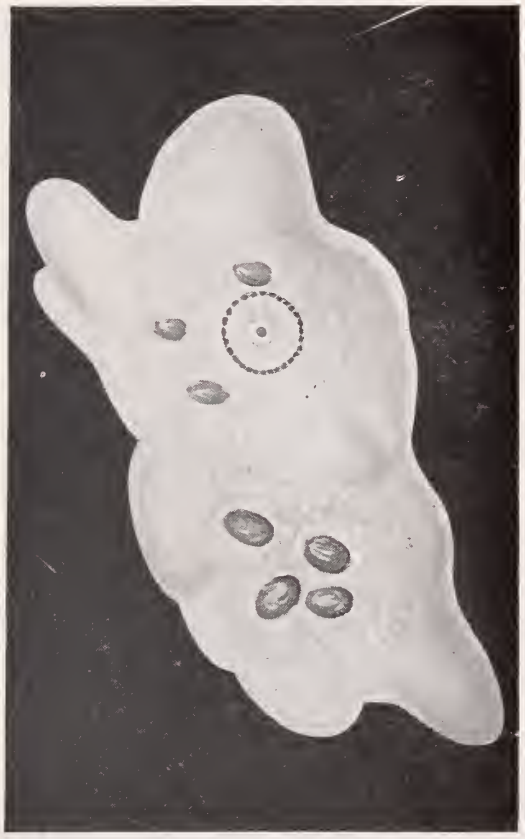
To prevent possible development of an incapacitating or even fatal illness and to eliminate a reservoir of infection in the community, diagnosing and treating[3] even seemingly healthy "carriers" and those having mild symptoms of amebiasis is advised.

Early diagnosis[1] is important because infection can be rapidly and completely cleared, with the proper choice of drugs and due consideration for the principles of therapy. For treatment of the bowel phase these authors find Diodoquin "most satisfactory."

For chronic amebic infections, Goodwin[4] finds Diodoquin to be one of the best drugs at present available.

Diodoquin, which does not inconvenience the patient or interfere with his normal activities, may be used in the treatment of acute or latent forms of amebiasis. If extraintestinal lesions require the use of emetine, Diodoquin may be administered concurrently. It is a well tolerated and relatively nontoxic orally administered amebacide, containing 63.9 per cent of iodine.

Diodoquin (diiodohydroxyquinoline), available in 10-grain (650 mg.) tablets, reduces the course of treatment to twenty days (three tablets daily). Treatment may be repeated or prolonged without serious toxic effect. It is accepted by the Council on Pharmacy and Chemistry of the American Medical Association. G. D. Searle & Co., Research in the Service of Medicine.



Endamoeba histolytica (*trophozoite*).

1. Hamilton, H. E., and Zavala, D. C.: Amebiasis in Iowa: Diagnosis and Treatment, J. Iowa M. Soc. *42*:1 (Jan.) 1952.

2. Goldman, M. J.: Less Commonly Recognized Clinical Features of Amebiasis, California Med. *76*:266 (April) 1952.

3. Weingarten, M., and Herzig, W. F.: The Clinical Manifestations of Chronic Amebiasis, Rev. Gastroenterol. *20*:667 (Sept.) 1953.

4. Goodwin, L. G.: Review Article: The Chemotherapy of Tropical Disease: Part I. Protozoal Infections, J. Pharm. & Pharmacol. *4*:153 (March) 1952.

News Items

Joseph C. Denniston, M.D., has opened offices in Louisville for the practice of Pediatrics. A graduate of Tufts Medical School, Boston, in 1940. Dr. Denniston served his residency at St. Joseph's Infirmary.

Richard F. Greathouse, M.D., a graduate of the University of Louisville School of Medicine in 1951, has opened an office in Louisville. Dr. Greathouse served his residency at Louisville General Hospital and Children's Hospital in Pediatrics.

John W. Epperson, M.D., formerly of Detroit, Michigan, recently opened an office in Owensboro, for the practice of obstetrics and gynecology. Following his graduation from the University of Maryland School of Medicine in 1943, Dr. Epperson interned at the University of Maryland Hospital, Baltimore, Maryland. He completed residencies in obstetrics and gynecology at the University Hospital, at Baltimore City Hospital and at Ohio State University Hospital.

George Cooley, Chicago, Associate Secretary of the AMA Council on Medical Services, attended a meeting of the KSMA Medical Services Committee at the Brown Hotel, October 20.

Aubrey Gates, Little Rock, Arkansas, Field Director of the AMA Council on Rural Health, met with the program committee for the Fourth Annual Rural Health Conference in the Headquarters Office on November 1.

John W. Ratliff, M.D., recently located in Lebanon, Marion County. A native Kentuckian, Dr. Ratliff is a 1953 graduate of the University of Louisville School of Medicine. He interned at Philadelphia General Hospital.

Charles R. Fisher, M.D., has left Flemingsburg after four months practice to enter the Madisonville Clinic. Dr. Fisher graduated from the University of Louisville School of Medicine in 1953 and interned at the Louisville General Hospital.

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Leonard Leight, M.D., a graduate of Washington University School of Medicine, St. Louis, in 1945, is serving as Assistant Professor of Medicine at the University of Louisville School of Medicine. Dr. Leight interned at Maimonides Hospital, Brooklyn, New York. He completed residencies there and at Veterans Administration Hospital, St. Louis.

David D. Drye, M.D., a 1953 graduate of the University of Louisville School of Medicine, has opened an office in Bradfordsville. Dr. Drye interned at Montreal General Hospital of McGill University.

Thomas G. Threlkeld, M.D., became associated with L. E. Johnson, M.D., in Russellville July 1. Dr. Threlkeld graduated from the University of Louisville School of Medicine in 1953. He interned the following year at St. Joseph Infirmary in Louisville.

Eugene Casey, M.D., a graduate of the George Washington University School of Medicine, has opened an office in Bowling Green for the practice of ophthalmology. Dr. Casey has completed residencies in his specialty at St. Elizabeth Hospital, Washington, D. C., and the V. A. Hospital in Louisville.

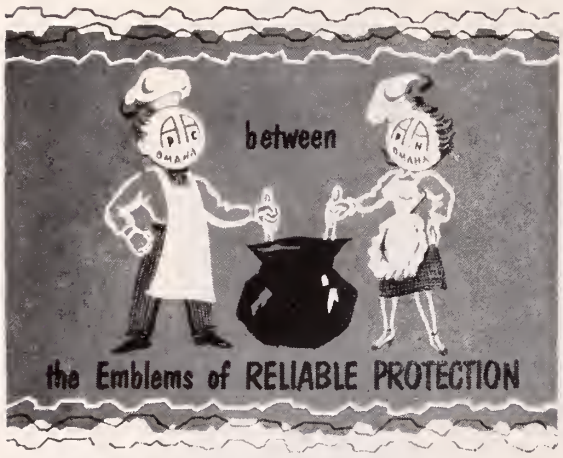
H. J. Schupbach, M. D., recently came from Salisbury, North Carolina V. A. Hospital to open an office in Owensboro for the practice of internal medicine. Following his graduation from Western Reserve University School of Medicine in 1947, Dr. Schupbach completed residencies at St. Raphael Hospital, Connecticut; Crippled Children's Hospital, Roanoke, Virginia, and Kennedy V. A. Hospital, Memphis, Tennessee.

B. Presley Smith, II, M.D., recently located in Owensboro. Dr. Smith, a 1953 graduate of the University of Louisville School of Medicine, interned at Louisville General Hospital.

Marvin W. Blankenship, M.D., a native of Arkansas, recently moved from Calvert City, Marshall County, to Fulton, Fulton County. Dr. Blankenship graduated from the University of Tennessee School of Medicine in 1951.

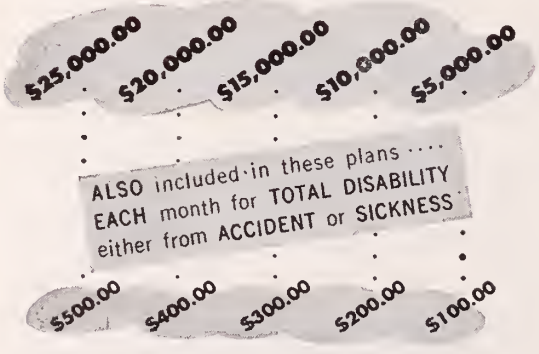
The next examination for the American Board of Physicial Medicine and Rehabilitation will be held in Philadelphia, June 5 and 6, 1955. The final date for filing applications is March 1. Applications for eligiblity to the examinations should be mailed to the Secretary, Earl C. Elkins, M.D., 30 N. Michigan Ave., Chicago 2, Illinois.

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Pertinent Paragraphs

There are approximately 6,680 known cases of active tuberculosis in Kentucky and possibly another 5,000 have TB and don't know it. Buy Christmas Seals and fight the disease.

Rural Health Week in North Carolina (September 26-October 2 was highlighted by the Seventh Annual Rural Health Conference, sponsored by the Medical Society of the State of North Carolina in cooperation with allied health groups, farm extension, and rural organizations. The one-day meeting, held in Raleigh, was attended by nearly 500 persons. Four outstanding rural health problems facing the state were discussed by a representative panel.

Applicants for the post of Medical Officer for the U.S. Naval Ordanance Plant, Louisville, are being sought by the Board of U. S. Civil Service Examiners. The starting salary is $5,940 per year and the requirements are as follows: "Applicants must be graduates of a Medical School of recognized standing with the degree of Doctor of Medicine, and must have completed a full rotating internship in an accredited hospital." Applicants should fill out Application Form 57, obtainable at any first or second-class Post Office and sent to: Board of U. S. Civil Service Examiners, Depts. of Army, Navy and Air Force, 445 Federal Buildng, Louisville 1, Kentucky.

More than 3,100 registrants, representing fifty nations, attended the Second World Congress of Cardiology which met jointly with the 27th Scientific Sessions of the American Heart Association at the National Guard Armory in Washington, D. C., September 12-17. The Third World Congress of Cardiology will be held in Brussels, Belgium in 1958.

During the week of January 17, 1955, the ninth annual University of Florida Midwinter Seminar will be held at the Sans Soci Hotel, Miama Beach. Lectures on Ophthalmology will be presented January 17, 18 and 19, and those on Otolaryngology on January 20, 21 and 22. All registrants are invited to attend the Midwinter Convention of the Florida Society of Ophthalmology and Otolaryngology on Wednesday afternoon, January 19. Last year 38 states were represented at the seminar.

Ninety-four cents out of every Christmas Seal dollar stays in your own state to fight tuberculosis. Buy and use Christmas Seals.

Announcement is made of a competitive examination for appointment of Medical Officers to the Regular Corps of the U. S. Public Health Service to be held in various cities through the country on February 15, 16, and 17. Entrance pay for an Assistant Surgeon with dependents is $6,017 per annum; for Senior Assistant Surgeon with dependents, $6,918. Application forms, which must be completed before January 12, may be obtained from the Chief, Division of Personnel, Public Health Service, Department of Health, Education, and Welfare, Washington 25, D. C.

The AMA's new "County Medical Public Relations Manual" was available for distribution to county PR leaders the first of December by KSMA. This booklet comprises the first comprehensive textbook on medical PR.

A two-day course in administration for superintendents and clinical directors of Kentucky's four State mental hospitals was given at the University of Louisville November 4 and 5. The course was arranged by the U. of L. Division of Adult Education and the personnel division of the State Departmtnt of Finance. Frank M. Gaines, Jr., State mental-health commissioner, said the course was arranged because too few doctors know administrative techniques.

AMA's Council on Medical Service through its Committee on Federal Medical Service is now preparing a regular newsletter in order to keep the medical profession informed on problems concerning veterans care. The first issue aroused so much interest that the committee will expand its mailing list to include state and county medical society leaders as well as committee members.

Physicians taking postgraduate work put number undergraduates in the country's medical schools, members of the Association of American Medical Colleges were told during their 65th annual meeting in French Lick, Ind., in October. It was reported that 45,000 practicing physicians, representing one-fourth of the nation's total, are receiving some type of post-graduate medical education. The current number of undergraduate medical students enrolled is 27,000.

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how VA facilities are being used

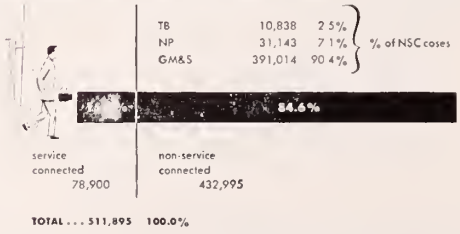
Patients Discharged During 1951

	TOTAL	SERVICE CONNECTED		NON SERVICE CONNECTED	
TB	21,388	10,550 =	2.1%	10,838 =	2.1%
NP	47,673	16,530 =	3.2%	31,143 =	6.1%
GM&S	442,834	51,820 =	10.1%	391,014 =	76.4%
TOTAL	511,895	78,900	15.4%	432,995	84.6%

The medical profession recommends that VA medical care be maintained for treatment of all service-connected cases and temporarily for all wartime veterans suffering from tuberculosis or neuropsychiatric disorders of non-service-connected origin, within limits of existing VA facilities, if they cannot afford private medical care. General medical and surgical patients with non-service-connected disabilities (now 76.4% of all VA patients) should not be entitled to "free" federal medical care.

In Viewing the VA Medical Program . . .

VA patients discharged during 1951



Of 511,895 patients discharged from VA hospitals in 1951, only 15.4% were treated for illnesses or injuries incurred as a result of military service. Physicians believe it is unsound to continue authorization of "free" lifetime medical care for those who suffer no mishap while in uniform, while other citizens with no military background must pay their own way.

In Memoriam

A. L. KINCHELOE, M. D.

Owensboro

1888 - 1954

A. L. Kincheloe, M.D., 66, died October 19, 1954, of a heart ailment at the Daviess County Hospital in Owensboro. Dr. Kincheloe had spent 39 of his 43 years of medical practice in Daviess County, coming to Owensboro in 1925 to be associated with the late Drs. George Barr and R. Haynes Barr.

A graduate of the University of Louisville School of Medicine in 1911, he spent one year as an intern in the Hazelwood Sanatorium at Louisville. Dr. Kincheloe served on the staff of the Owensboro-Daviess County Hospital, the County Health Board and the County Board of Education. During World War II, he served with the armed forces.

PHILIP H. NEVITT, M. D.

Louisville

1879 - 1954

Philip H. Nevitt, M.D., 75, died October 28, 1954, at St. Joseph's Infirmary, in Louisville.

Dr. Nevitt, who for 28 years was with the Veterans Administration in Louisville, had retired five years ago. During the years he spent with the V. A., he had checked the complaints of approximately 50,000 veterans of both World Wars.

Dr. Nevitt graduated from the University of Louisville School of Medicine in 1901. He was a member of the American Legion.

JOHN F. HAHS, M. D.

La Center

1874 - 1954

Dr. John F. Hahs died of coronary occlusion October 20, 1954, at his home in La Center, Kentucky. Dr. Hahs had practiced medicine in Ballard County for 56 years.

For many years Dr. Hahs served as surgeon for the Illinois Central Railway Company. He served in World War I with the 498 Aero-Squadron in France as Captain and remained in the U. S. Army Reserve until 1939 with the rank of Major.

Dr. Hahs was born in Jappa, Illinois. He was a graduate of the College of Physicians and Surgeons, St. Louis. He was prominent in church and civic affairs of his community.

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County Society Reports

CALLOWAY

The monthly meeting of the Calloway County Medical Society was held in the chapel of the Murray Hospital on September 7. Administrator Warming reported that he had asked Judge Waylon Rayburn about the possibility of the county providing funds to care for some of the county's indigent patients when they are hospitalized. Judge Rayburn said that no funds were available now, but said that if something could be done about the four inmates at the County Poor Farm that this might release several thousand dollars a year for other purposes.

J. C. Hart, M.D., made a motion, seconded by Hugh Houston, M.D., that a committee be appointed to investigate the conditions at the County Poor House and make recommendations to the Calloway County Fiscal Court. All approved. C. C. Lowry, M.D., president, appointed the following to serve on this committee: Dr. Houston, chairman; A. D. Butterworth, M.D., and Charles Clark, M.D.

Other physicians present included: Robert Hahs, C. H. Jones, O. K. Mason, R. M. Mason, Kenneth Ross, C. L. Tuttle, and Birdsall Carle and Administrator Warming.

C. C. Lowry, M.D., President
J. L. Hopson, M.D., Secretary

CALLOWAY

The October meeting of the Calloway County Society was held October 5, 1954, at the Murray Hospital chapel. The following physicians were present: A. D. Butterworth, M.D., Hugh Houston, M.D., C. C. Lowry, M.D., O. H. Mason, M.D., Kenneth Ross, M.D., Birdsall Carle, M.D.

The meeting was called to order by Dr. Lowry, and the minutes of the meeting of September 7 were read and approved.

Dr. Houston, chairman of a committee appointed to investigate conditions at the County Poor House and to make recommendations to the Calloway County Fiscal Court reported that he had not yet been advised of any action taken by the Fiscal Court.

A report of the Kentucky State Medical Association meeting in Louisville was given by Dr. Houston. The following doctors from Murray attended the meeting: Hugh Houston, M.D., John Quertermous, M.D., A. D. Butterworth, M.D., and J. L. Hopson, M.D.

Dr. Houston told the group of the tape recordings made by the California Medical Society, giving the summary of important recent medical work, the tape being obtainable by county societies at $4 per month. It was agreed by the members present to put on one such pro-

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gram and to decide following this if they should follow the practice of putting on one program each month at the county seciety meeting.

J. L. Hopson, M.D., Secretary

PIKE

The Pike County Medical Association held its regular monthly meeting on October 19, with Charles C. Rutledge, M.D., president, in charge.

It was suggested that the Blue Cross-Blue Shield in Huntington be contacted in regard to the possibility of having a local physician appointed to their board of directors. It was felt that having a local member on their board would enable this group to keep more closely in touch with this organization.

A scientific program was presented by Orville Zeller, M.D., anesthesiologist at the Pikeville Methodist Hospital. The subject of his paper was "Regional Anesthesia as Concerns the Geriatric Patient." There was considerable discussion by the members following the presentation of this paper.

Russell H. Davis, M.D., Secretary

McCRACKEN

The regular dinner meeting of the McCracken County Medical Society was held October 27, with Keith Sloan, M.D., presiding.

The scientific program consisted of a discussion of maternal and child health by the State Director of this department, L. R. Mezera, M.D. The program was followed by a question and answer period.

A letter of application to the society from Roscoe Faulkner, M.D., of Salem, Kentucky, was read and referred to the Board of Censors.

Doctor Sloan reminded the society of its duty to support the Community Chest.

Motion was made by Chester Blanton, M.D., and seconded by William Smith, M.D., that the society go on record as being in favor of the proposal for sewage disposal. Motion was carried.

Discussion of the medical forum was given by Dr. Johnson regarding reinstitution of this program for this year. Motion was made by Hubert R. Holland, M.D., and seconded by Charles B. Billington, M.D., that action be delayed on this matter until the next meeting. The motion was carried.

M. W. Fowler, Jr., M.D., Secretary

WARREN-EDMONSON

The Warren-Edmonson County Medical Society held its regular meeting at the Helm Hotel, October 12, with the president, R. O. Green, M.D., presiding.

The Warren County Medical Society approved the appointment of physicians Frank H. Moore, Samuel E. Paris, and A. D. Donnelly, Jr., to the Warren County Board of Health.

G. M. Wells, M.D., the county health officer, discussed immunization records of children and pointed out that the majority of the men in practice were not notifying the health department when immunizations were made. He requested that the county members make their reports so that immunization records for Warren County would not be so low.

Announcement was made of the election of Jesse T. Funk, M.D., as vice president of the KSMA, and the re-election of L. O. Toomey, M.D., as counselor for the sixth district. A report of the delegate, J. T. Gilbert, M.D., was made to the county society.

The program for the evening was a motion picture on the treatment of hypertension.

Charles M. Francis, M.D., Secretary

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Journal of the

KENTUCKY STATE MEDICAL ASSOCIATION

Edited by

Bruce Underwood, M. D.

Under Supervision of the Council

Volume Fifty-Two

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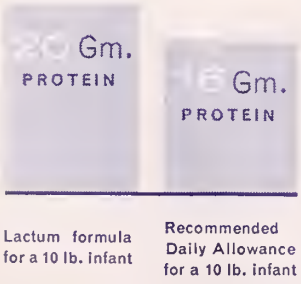


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1. Jeans, P. C., in A.M.A. Handbook of Nutrition, Philadelphia, Blakiston, 1951, pp. 275-298. 2. Stare, F. J., and Davidson, C. S., in The Proteins, American Medical Association, 1945.

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